

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

7 9 3 0 1 2 1  
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>DONALD Charles HACKEY JR.</b>		2a. DATE OF DEATH MONTH DAY YEAR <b>12 3 79</b>		2b. HOUR <b>7:38 PM</b>	
3. SEX <b>Male</b>	4. RACE <b>Mulatto</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>11 06 77</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>2</b> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY</b> MD.	
10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>THE JOHNS HOPKINS HOSPITAL</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Child</b>		12b. KIND OF BUSINESS OR INDUSTRY
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Maryland</b>			13b. CITY OR TOWN <b>Taneytown</b>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>Donald Charles Hackey, Sr.</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Patricia Ann Dutrow</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>218-90-7682</b>		17. INFORMANT ADDRESS <b>P.A. Dutrow, 40 W. Balt. St., Taneytown</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>failure to wear from bypass</b> <b>7450</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>persistent right to left cardiac shunting</b> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 1/2 HRS</b> <b>3 HRS</b>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>Truncus Arteriosus Cardiac Malformation</b>					
19a. DATE OF OPERATION <b>12/3/79</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Truncus Arteriosus</b>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (1) <b>this hospital</b> attended the deceased from <b>12/1</b> , 19 <b>79</b> , to <b>12/3</b> , 19 <b>79</b> , that (1) <b>we</b> last saw the deceased alive on <b>12/3</b> , 19 <b>79</b> , and that in (my) <b>four</b> opinion death occurred on the date and hour and from the causes stated above. (If we did not view the body after death.)					
22b. SIGNATURE <b>Samuel Hassenbusch MD</b>		DEGREE <b>MD</b>		22c. DATE SIGNED <b>12/3/79</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>SAMUEL HASENBUSCH</b>		22e. ADDRESS <b>JOHNS HOPKINS HOSPITAL</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>12/7/79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Fairview Cemetery</b>	
23d. LOCATION CITY OR TOWN <b>Frederick Fred.</b>		STATE <b>MD</b>		25a. DATE RECEIVED BY REGISTRAR <b>DEC 12 1979</b>	
24. FUNERAL DIRECTOR NAME <b>G.D. Stauffer, Rt. 10, Box 66, Fred., MD</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>			

MEDICAL CERTIFICATION

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

14

DOWNALL

COOKES

HACKNEY ST.

WARRINGTON CITY

BRITAINERS THE JAMES HOPKINS HOSPITAL

BRITAINERS THE JAMES HOPKINS HOSPITAL

BRITAINERS

Frederick





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH-16 20M  
(VRA 15, 4) 7/78

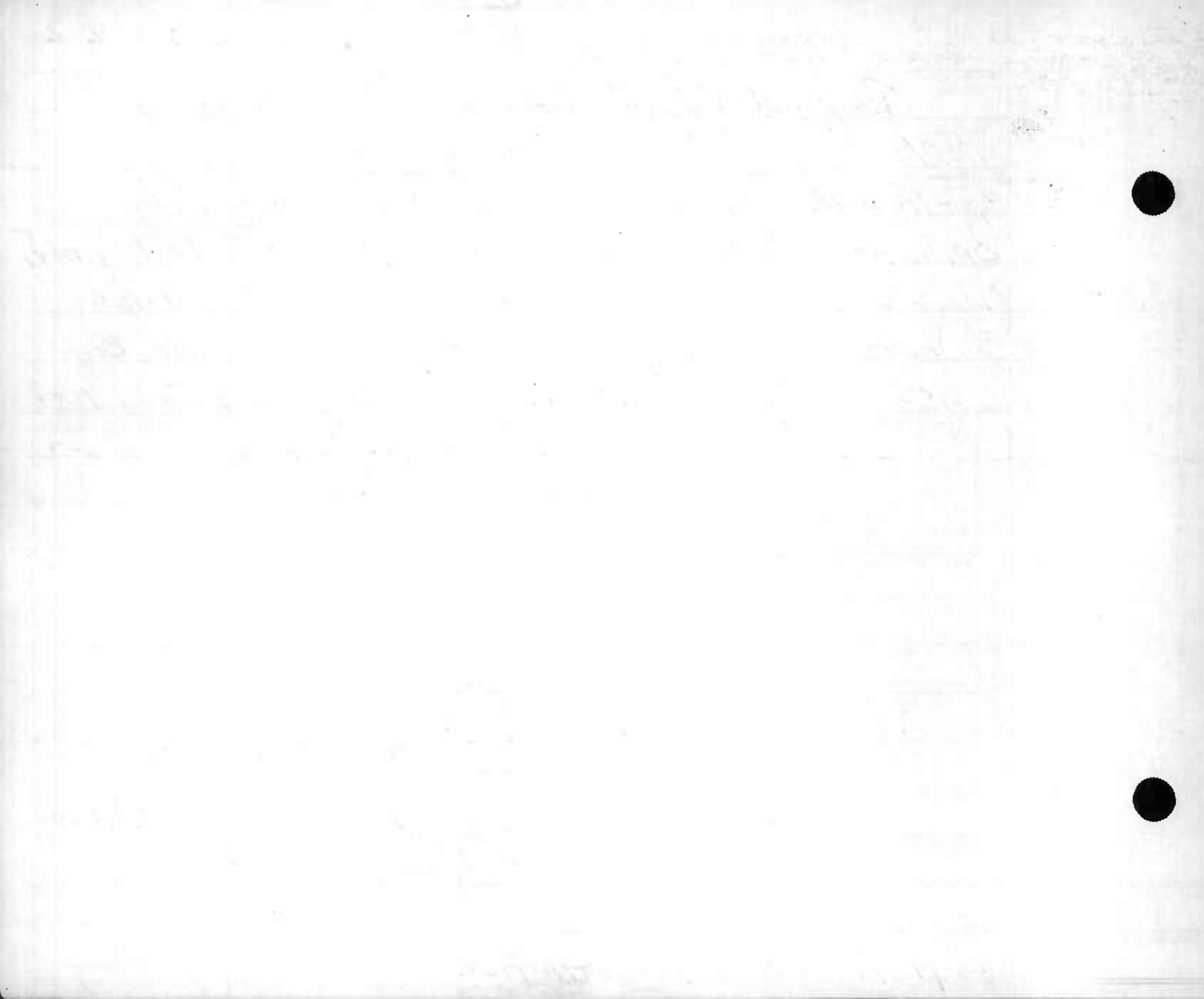
STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										7 9 3 0 1 2 2	
FOR 1 - STATE REGISTRAR				REG. NO.							
1 DECEASED NAME (TYPE OR PRINT) <b>RAYMOND EDWARD HACKEY</b>				2a DATE OF DEATH MONTH DAY YEAR <b>12-15-79</b>				2b HOUR M			
3 SEX <b>male</b>		4 RACE <b>Col.</b>		5 DATE OF BIRTH MONTH DAY YEAR <b>10-28-1928</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>51</b>		7 IF UNDER 1 YEAR MONTHS DAYS HOURS MIN			
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Hunts Town, Md.</b>		7b CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.					
10 CITY OR TOWN OF DEATH <b>Baltimore</b>		11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>2116 Westwood Ave.</b>				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Dried Operator Locke Irigate</b>		12b KIND OF BUSINESS OR INDUSTRY			
13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b STATE <b>Maryland</b>		13b COUNTY		13c CITY OR TOWN <b>Balto.</b>		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS <b>2116 Westwood Ave.</b>			
14 FATHER'S NAME FIRST MIDDLE LAST <b>James O. Grey</b>				15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Glady's Hackey</b>							
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>yes</b>				16b SOCIAL SECURITY NO. <b>218243465</b>		17 INFORMANT ADDRESS <b>Mrs. Mary Hackey 2116 Westwood Ave.</b>					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>acute myocardial infarction</b> <b>410 -</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerosis</b> (c) <b>Cardiovascular Disease</b>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)							
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE							
22a I certify that (I) (this hospital) attended the deceased from <b>8122</b> , 19 <b>79</b> , to <b>9125</b> , 19 <b>79</b> , that (I) (we) lost saw the deceased alive on <b>9125</b> , 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b SIGNATURE <b>Rifat Abousy</b>				DEGREE <b>MD</b> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c DATE SIGNED <b>12/18/79</b>			
22d PHYSICIAN'S NAME (TYPE OR PRINT) <b>Rifat Abousy</b>				22e ADDRESS <b>2300 Garrison Blvd.</b>							
23a BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b DATE <b>12/19/79</b>		23c NAME OF CEMETERY OR CREMATORY <b>mt. Auburn</b>		23d LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore</b>					
24 FUNERAL DIRECTOR NAME <b>Joseph L. Russ</b>				ADDRESS <b>2222 W. North Ave.</b>		25a DATE REC'D. BY REGISTRAR <b>DEC 18 1979</b>		25b REGISTRAR'S SIGNATURE <b>Henry McCready</b>			

MEDICAL CERTIFICATION

9 9

BP

1503



DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

7 9 3 0 1 2 3

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>JOHN E. HADEL</b>			2a. DATE OF DEATH MONTH <b>12</b> DAY <b>30</b> YEAR <b>79</b>			2b. HOUR <b>8:00 P.M.</b>					
3. SEX <b>MALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH MONTH <b>10</b> DAY <b>11</b> YEAR <b>20</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>59</b> YRS		7. IF UNDER 1 YEAR MONTHS <b>0</b> DAYS <b>0</b>		7. IF UNDER 24 HRS HOURS <b>0</b> MIN. <b>0</b>	
8a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MARYLAND</b>		8b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE</b> City MD.					
10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>VAMC BALTIMORE, MARYLAND 21218</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Carpenter, Ship yard</b>			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>MARYLAND</b>			13b. COUNTY		13c. CITY OR TOWN <b>BALTIMORE</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>4 W. OSTEND STREET</b>		
14. FATHER'S NAME FIRST <b>Samuel</b> MIDDLE <b>W.</b> LAST <b>Hadel</b>				15. MOTHER'S MAIDEN NAME FIRST <b>Margaret</b> MIDDLE <b>Adelia</b> LAST <b>Holland</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>YES</b>			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>WWII</b>		17. INFORMANT <b>Mrs. Edna Lippy, Same as above</b>		ADDRESS				
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>CARDIOPULMONARY ARREST</b> <b>585-</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>CHRONIC RENAL FAILURE.</b> DUE TO, OR AS A CONSEQUENCE OF (c) CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>HRS</b> <b>YRS</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:											
19a. DATE OF OPERATION <b>N/A</b>			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>N/A</b>			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <b>N/A</b>			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>N/A</b>			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) <b>N/A</b>					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> <b>N/A</b>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) <b>N/A</b>			21f. LOCATION STREET <b>N/A</b> CITY OR TOWN COUNTY STATE					
22a. I certify that <input checked="" type="checkbox"/> (this hospital attended the deceased from <b>DECEMBER 27</b> 19 <b>79</b> to <b>DECEMBER 30</b> 19 <b>79</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>DECEMBER 30</b> 19 <b>79</b> and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, <input type="checkbox"/> (we) (do not) see any view the body after death.											
22b. SIGNATURE <b>Bruce D. Behounek, M.D.</b>						DEGREE <b>M.D.</b>		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>12/31/79</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>BRUCE D. BEHOUNEK, M.D.</b>						22e. ADDRESS <b>COEN RAVEN VA. HOSPITAL</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>Jan. 3, 1980</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cemetery</b>			23d. LOCATION CITY OR TOWN <b>Baltimore</b> COUNTY <b>Maryland</b> STATE			
24. FUNERAL DIRECTOR NAME <b>McGully Funeral Home, 130 E. Font Ave. Balto. Md.</b> ADDRESS						25a. DATE REC'D. BY REGISTRAR <b>JAN 4 1980</b>		25b. REGISTRAR'S SIGNATURE <b>Anthony McCreedy</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

RECEIVED  
JAN 10 1950  
U.S. DEPARTMENT OF AGRICULTURE  
WASHINGTON, D.C.

TO: DIRECTOR, AGRICULTURAL RESEARCH SERVICE  
FROM: ASSISTANT SECRETARY, AGRICULTURAL RESEARCH SERVICE  
SUBJECT: [Illegible]

RE: [Illegible]  
[Illegible]  
[Illegible]

[Illegible]  
[Illegible]  
[Illegible]

[Illegible]  
[Illegible]  
[Illegible]

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

7 9 3 0 1 2 4

REG. NO.

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST	2a. DATE OF DEATH			2b. HOUR
STEVEN S. HAGAN					12 31 79			1:35 AM
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR		
Male	CAUCASIAN	MONTH DAY YEAR 1 14 13		66 YRS.		IF UNDER 24 HRS.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		10. MD.		
Md.	U.S.			CITY				
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		
BALTIMORE CITY	UNIV OF MD HOSPITAL			RETIRED		Electrician		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				13d. INSIDE CITY LIMITED		13e. STREET ADDRESS		
13a. STATE 13b. COUNTY				13c. CITY OR TOWN				
MD 13b. COUNTY				BALTIMORE		3041 Kenyon Ave.		
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		
Edgar		Mary		yes		unknown		
17. INFORMANT		ADDRESS		17. INFORMANT		ADDRESS		
Hilda Hagan (wife)		same address		Hilda Hagan (wife)		same address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY:							15 MINUTES	
IMMEDIATE CAUSE (a) CARDIAC FAILURE								
5789 DUE TO, OR AS A CONSEQUENCE OF							SEVERAL HOURS	
(b) INCREASED METABOLIC DEMANDS								
DUE TO, OR AS A CONSEQUENCE OF							4 DAYS	
(c) SEPSIS								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)								
MENINGITIS, PRESUMED SEPTIC THROMBOSIS OF BASILAR A.								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
12/12/79		LOWER GI BLEEDING		YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
		P.M. 19						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from December 1, 1979, to December 31, 1979, that (I) (we) last saw the deceased alive on December 31, 1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we did not view the body after death.)								
22b. SIGNATURE				DEGREE		22c. DATE SIGNED		
Kevin M. Cooke, MD				ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		12/31/79		
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS				
K. COOKE				UNIV OF MD HOSPITAL				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE		
Burial		1/3/80		Holy Redeemer		Balto. Md.		
24. FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE				
S. Imuniek Funeral Home, Inc.		3331 Brehms Lane Balto. Md. 21213		JAN 3 1980		Rafael Melendez		

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#17, Film 3540 2/15/80 kam

STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

7 9

3 0 1 2 5

FOR  
1 - STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>Florine</b>		FIRST <b>Florine</b>		MIDDLE <b>( HAGGINS )</b>		LAST <b>HAGGINS</b>		2a. DATE OF DEATH MONTH DAY YEAR <b>December 5, 1979</b>		2b. HOUR <b>9-58 A M</b>	
3 SEX <b>Female</b>		4 RACE <b>Negro</b>		5 DATE OF BIRTH MONTH DAY YEAR <b>9 15 1911</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>68</b> YRS.		7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>North Carolina</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>North Carolina</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.		10 CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Maryland General Hospital</b>	
10 CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Maryland General Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		13a. STATE <b>Maryland</b>		13b. COUNTY <b>Baltimore</b>	
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Baltimore</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>517 North Calhoun Street</b>		14. FATHER'S NAME FIRST MIDDLE LAST <b>Quince Cotton</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Quince Cotton</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Florlen Hocutt</b>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>219-16-5145</b>		17 INFORMANT <b>Luelle Ansquier</b> <b>Mary C. Williams</b>		18 ADDRESS <b>805 Stonestreet Avenue</b> <b>Rockville, Maryland</b>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiopulmonary arrest</b> <b>1570</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Possible carcinoma of head of the pancreas</b> (c) <b>Possible carcinoma of head of the pancreas</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)		19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		22a. I certify that (X) (this hospital) attended the deceased from <b>October 2</b> , 19 <b>79</b> , to <b>December 5</b> , 19 <b>79</b> , that (X) (we) last saw the deceased alive on <b>December 5</b> , 19 <b>79</b> , and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above, (X) (we) (did) (not) view the body after death.		22b. SIGNATURE <b>Saied Talaie</b> DEGREE <b>M.D.</b>		22c. DATE SIGNED <b>12/5/79</b>	
22b. SIGNATURE <b>Saied Talaie</b> DEGREE <b>M.D.</b>		22c. DATE SIGNED <b>12/5/79</b>		22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Saied Talaie, M.D.</b>		22e. ADDRESS <b>c/o Maryland General Hospital</b>		23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>12/9/1979</b>	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>12/9/1979</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Church Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Ement, N.C.</b>		24 FUNERAL DIRECTOR NAME <b>Wm. C. March F/H 1101 East North Avenue</b>		25a. DATE REC'D. BY REGISTRAR <b>DEC 10 1979</b>	
24 FUNERAL DIRECTOR NAME <b>Wm. C. March F/H 1101 East North Avenue</b>		25a. DATE REC'D. BY REGISTRAR <b>DEC 10 1979</b>		25b. REGISTRAR'S SIGNATURE <b>Richard M. Brady</b>		25c. REGISTRAR'S SIGNATURE <b>Richard M. Brady</b>		25d. REGISTRAR'S SIGNATURE <b>Richard M. Brady</b>		25e. REGISTRAR'S SIGNATURE <b>Richard M. Brady</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Walden (Central Hospital)

010110

452

135253

C/O Kariwala General Hospital

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

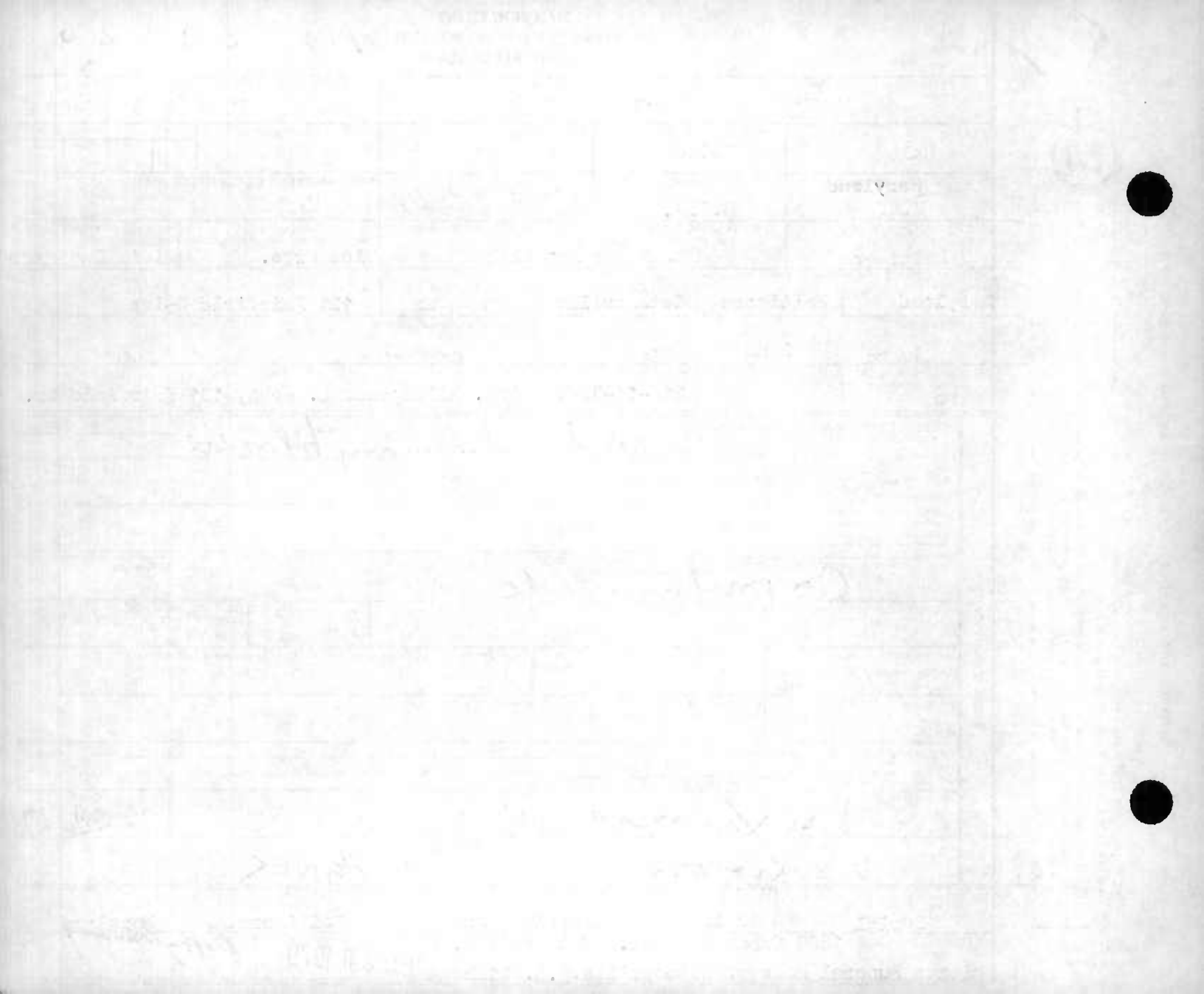
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified once.

1. FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) EDWARD A. HAHN			2a. DATE OF DEATH MONTH DAY YEAR 12 23 79			2b. HOUR 9:23 P.M.		
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 11 24 07		6. AGE (IN YEARS LAST BIRTHDAY) 72 YRS.		
7a. BIRTHPLACE (COUNTRY) Maryland U.S.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore MD.		
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) St. Agnes Hospital			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Vice Pres.		12b. KIND OF BUSINESS OR INDUSTRY Civil Engineer	
13a. STATE Maryland			13b. COUNTY Baltimore		13c. CITY OR TOWN Catonsville		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Edward John Hahn			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Catherine Link					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 214-14-7047		17. INFORMANT ADDRESS Mrs. Hildegard L. Hahn, 121 Fairfield Dr.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 515- IMMEDIATE CAUSE (a) <u>Marked Pulmonary Fibrosis</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) _____ DUE TO, OR AS A CONSEQUENCE OF PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a): <u>Coronary Artery Disease</u>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE V. Suxumar MD				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 12-28-79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) V. SUXUMAR				22e. ADDRESS ST. AGNES				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12/28/79		23c. NAME OF CEMETERY OR CREMATORY Lorraine Park		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Maryland		
24. FUNERAL DIRECTOR NAME Witzke Funeral Home of Catonsville, P.A. 21228				25a. DATE REC'D BY REGISTRAR DEC 26 1979		25b. BY REGISTRAR		





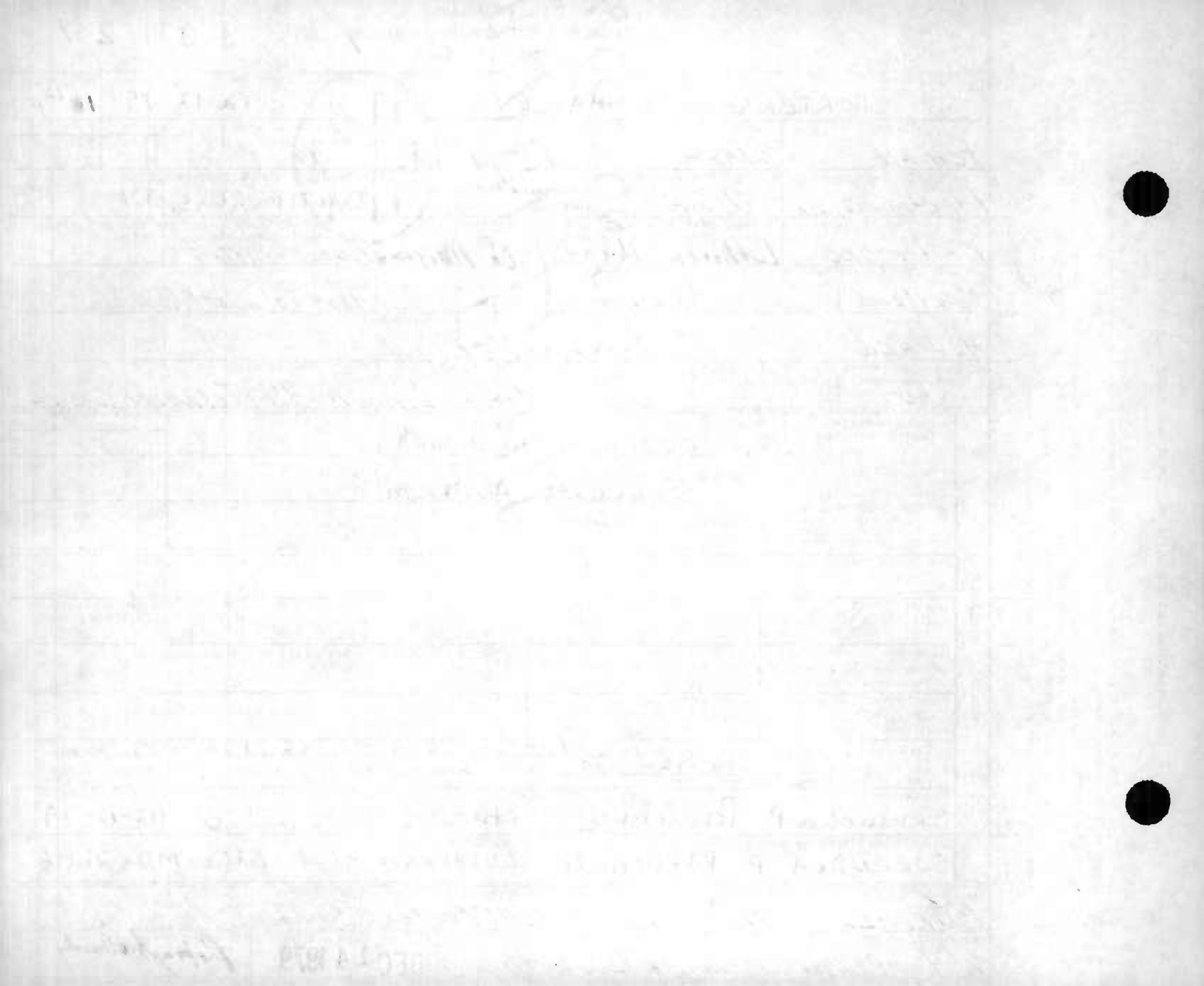
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
1. FOR STATE REGISTRAR		7 9 3 0 1 2 7									
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR MIN	
HORTENSE		HAILEY						12-12-79		10 <sup>15</sup> P.M.	
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN	
Female		Black		1 24 32		48 YRS.					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
North Carolina		U.S.A.				BALTIMORE CITY MD.					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Baltimore		Lutheran Hospital of Maryland						Nurse Assistant			
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS			
Maryland		Balto.		Baltimore		YES		9819 Tolworth Circle			
14. FATHER'S NAME FIRST MIDDLE LAST				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST							
Howard Johnson				Veklow							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS					
no				Nancy Linnen		9819 Tolworth Circle					
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c): PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CEREBRAL HAEMORRAGE</u> <u>430-</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>CEREBRAL ANEURYSM</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (this hospital) attended the deceased from <u>12-09-</u> , 19 <u>79</u> , to <u>12-12-</u> , 19 <u>79</u> , that (we) last saw the deceased alive on <u>12-12-</u> , 19 <u>79</u> , and that in (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (do) (do not) view the body after death.											
22b. SIGNATURE				DEGREE				22c. DATE SIGNED			
Suresh P. Paruchuri				MD				12-12-79			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS							
SURIENDRA P. PARUCHURI				LUTHERAN HOSP. BAL. MD-21216.							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE					
Burial		12/12/79		Church Cemetery		Sanford, North Carolina					
24. FUNERAL DIRECTOR NAME ADDRESS				25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
William C. Brown Community F.A. 1206 West North Ave				DEC 14 1979		[Signature]					

BP



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PH. 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO. 30128			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Gordon (nmi) Hall												2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR 12 3 19 79		2b. HOUR M	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 7/4/1909		6. AGE (IN YEARS) LAST BIRTHDAY) 70 YRS.		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		2c. DATE PRONOUNCED DEAD MONTH DAY YEAR 12 3 19 79		2d. HOUR P.M.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) N. Carolina				7b. CITIZEN OF WHAT COUNTRY? U.S.A.				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City, MD.			
10. CITY OR TOWN OF DEATH Baltimore				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 612 W. Lafayette Avenue				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Never Employed				12b. KIND OF BUSINESS OR INDUSTRY (Blind)			
13a. STATE Md.				13b. COUNTY ----		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 612 W. Lafayette Ave. 21228					
14. FATHER'S NAME FIRST MIDDLE LAST UNKNOWN						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST UNKNOWN									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No				16b. SOCIAL SECURITY NO. 214.76.4430		17. INFORMANT ADDRESS Chesley R. Hall, Jr. 1101 St. Paul St. Balto. Md 21202									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Cardiovascular Disease 4292 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c) DUE TO, OR AS A CONSEQUENCE OF APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH															
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).															
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .															
ACTUAL SIGNATURE Virginia L. Dolan				TITLE (SPECIFY) Assistant				DATE SIGNED 12/4/79							
EXAMINER'S NAME (TYPE OR PRINT) Virginia L. Dolan, M.D.				ADDRESS 111 Penn Street											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation				23b. DATE 12/5/1979		23c. NAME OF CEMETERY OR CREMATORY Green Mount				23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Md.					
24. FUNERAL DIRECTOR NAME Walter Brooks Bradley Inc. Balto., Md.						25a. DATE REC'D. BY REGISTRAR DEC 6 1979		25b. REGISTRAR'S SIGNATURE Dorothy McCreedy							



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. You may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR  
STATE  
REGISTRAR

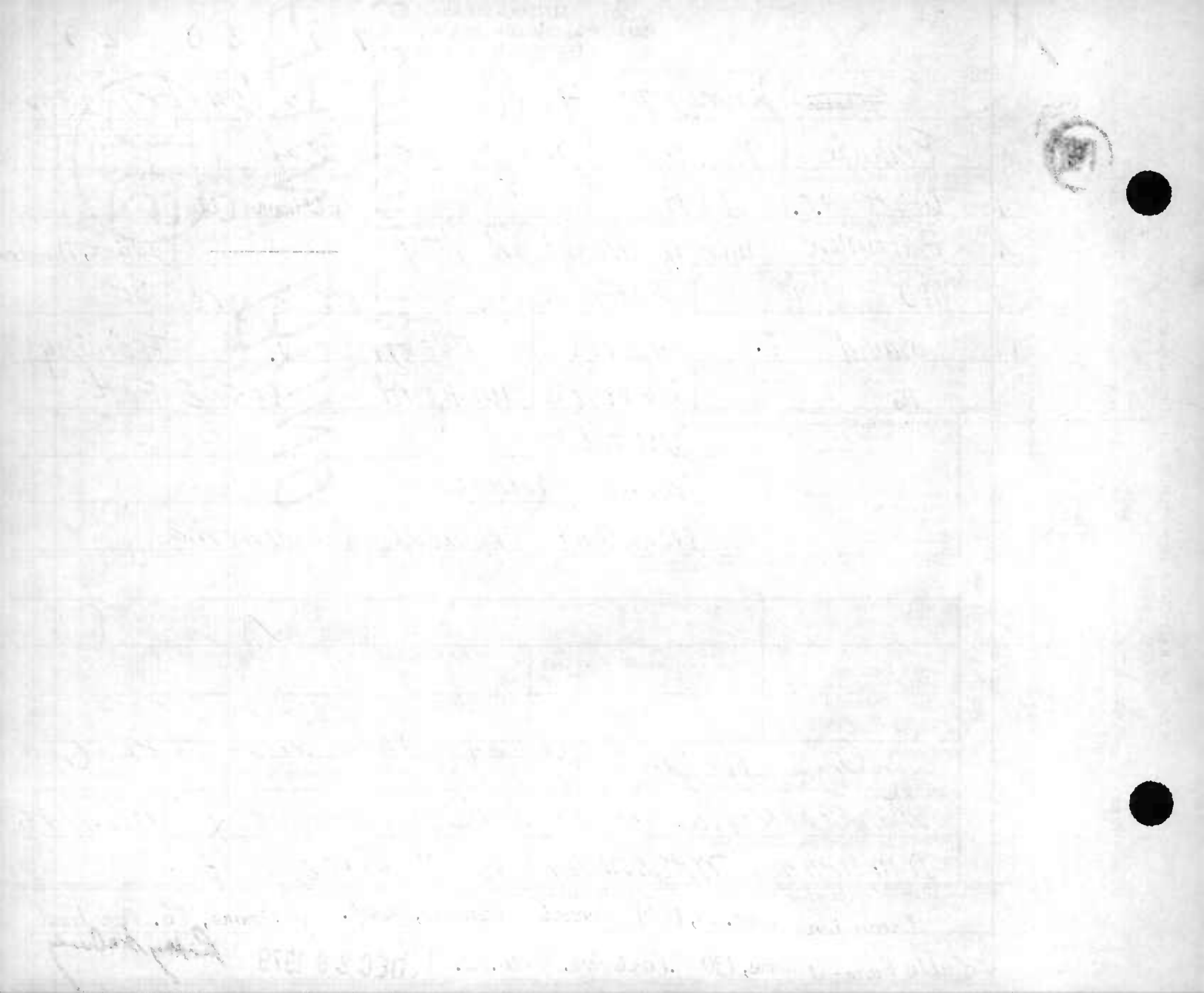
STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

9 30129

1. DECEASED NAME (TYPE OR PRINT) <b>Jenny M. Hall</b>		2a. DATE OF DEATH MONTH DAY YEAR <b>12/24/79</b>		2b. HOUR <b>2:55 P.M.</b>
3 SEX <b>Female</b>	4 RACE <b>White</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>11 29 55</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>24</b> YRS.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>USA N.C.</b>	7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD
10. CITY OR TOWN OF DEATH <b>Baltimore</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Univ. of Maryland Hosp.</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>cashier</b>	12b. KIND OF BUSINESS OR INDUSTRY <b>Theater</b>
13a. STATE <b>MD</b>		13b. COUNTY <b>Baltimore</b>	13c. CITY OR TOWN <b>Baltimore</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST <b>David C. Harris</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Evelyn V. Fleming</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>216 684855</b>		17. INFORMANT <b>Husband</b>
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>uremia</b> 1809 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>Renal failure</b> (c) <b>Recurrent cervical carcinoma</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)				
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE
22a. I certify that (1) (this hospital) attended the deceased from <b>Dec 24, 19 79</b> to <b>Dec 24, 19 79</b> , that (1) (we) last saw the deceased alive on <b>Dec 24, 19 79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did) (did not) view the body after death.				
22b. SIGNATURE <b>Marciana Washington M.D.</b>		DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>12/24/79</b>
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>MARCIANA WASHINGTON</b>		22e. ADDRESS <b>22 S. Greene St.</b>		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>		23b. DATE <b>Dec. 28, 1979</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Security Process, (Cremt. Baltimore, Co. Maryland)</b>	
24. FUNERAL DIRECTOR NAME <b>McCully Funeral Home, 130 E. Fort Ave. Balto. Md.</b>		25a. DATE REC'D. BY REGISTRAR <b>DEC 28 1979</b>		





FOR STATE REGISTRAR		DEPARTMENT OF HEALTH AND MENTAL HYGIENE		7 9 3 0 1 3 0	
1. DECEASED NAME (TYPE OR PRINT)		2a. DATE OF DEATH		2b. HOUR	
JOSEPH HALL		DECEMBER 08, 1979		08:13 PM	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)	7. BALTIMORE CITY OR COUNTY OF DEATH	
MALE	NEGRO	9 MONTH 17 YEAR 1903	76	BALTIMORE CITY MD.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH		
MARYLAND	U.S.A.		BALTIMORE CITY MD.		
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY
BALTIMORE	THE JOHNS HOPKINS HOSPITAL				
13a. STATE		13b. COUNTY	13c. CITY OR TOWN	13d. STREET ADDRESS	
MARYLAND	A.A.	ANNAPOLIS		918 Chesterfield Road	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME			
JEREMIAH HALL		ELZENA JONES			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS		
NO		214-05-1078	MARGARETE HALL 918 Chesterfield Rd.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a):					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
4151 Probable Pulmonary Embolus					11 hours
DUE TO, OR AS A CONSEQUENCE OF					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					
DUE TO, OR AS A CONSEQUENCE OF					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):					
H/o Tuberculosis Meningitis					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?	
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE		DEGREE		22c. DATE SIGNED	
Lawrence S. Friedman, MD		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		12/9/79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS			
LAWRENCE S. FRIEDMAN		Johns Hopkins Hospital			
23a. BURIAL, CREMATION, REMOVAL		23b. DATE	23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE
BURIAL		12-12-1979	MT. TABOR CHURCH CEME.		Chesterfield Maryland
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE	
WILLIAM REESE & SONS MORTUARY, P.A.		Annapolis, Md.		DEC 11 1979	

400 410 420

DEC 1 1979



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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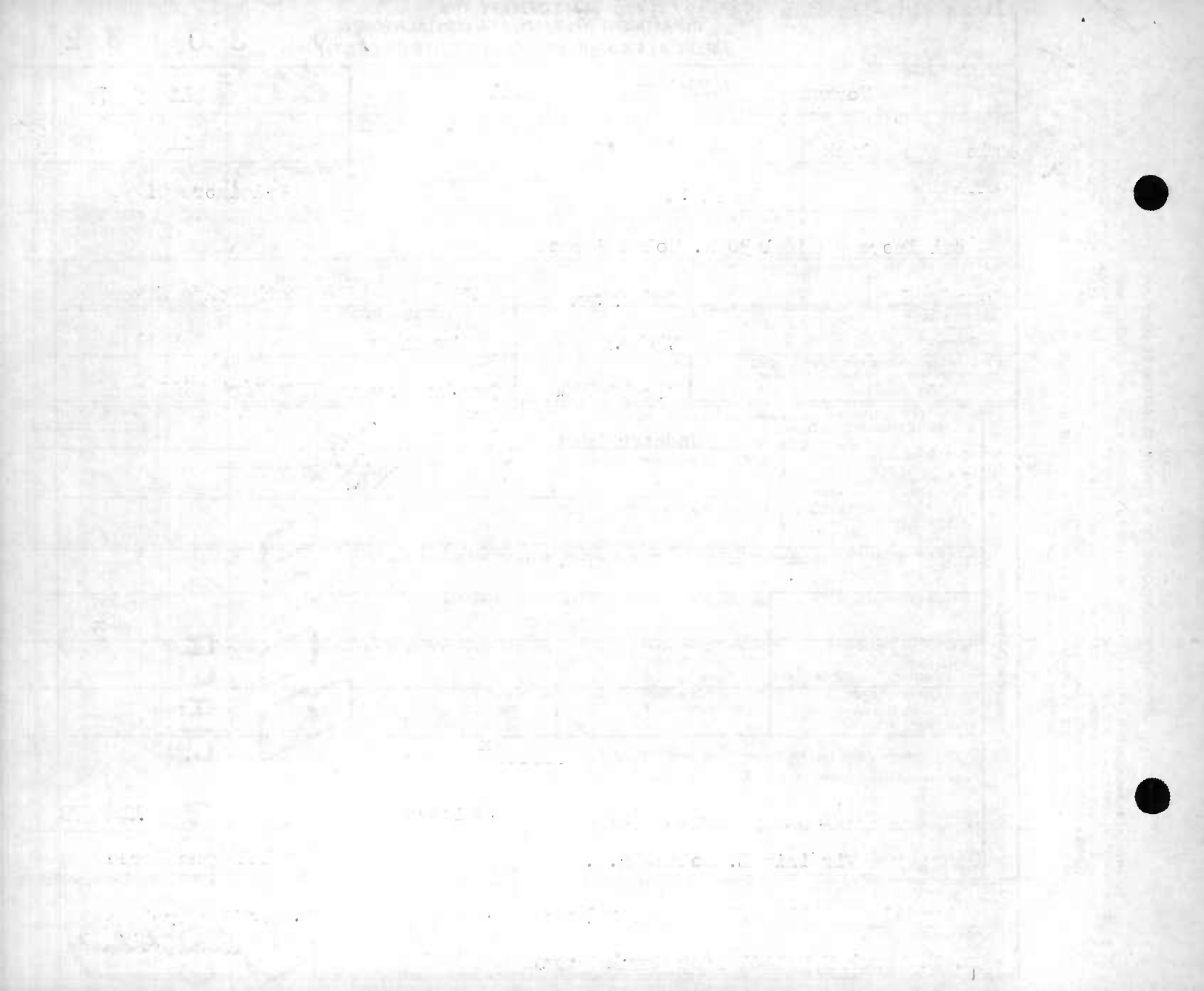
STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										7 9 3 0 1 3 1
1. FOR STATE REGISTRAR					REG. NO.					
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Nathaniel Hall</i>					2a. DATE OF DEATH MONTH DAY YEAR <i>December 9, 1979</i>			2b. HOUR <i>8:00 P.M.</i>		
3 SEX <i>Male</i>		4 RACE <i>Black</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>4 6 47</i>		6 AGE (IN YEARS LAST BIRTHDAY) <i>32</i>		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Maryland</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. <input checked="" type="checkbox"/> MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Baltimore City</i> MD.				
10. CITY OR TOWN OF DEATH <i>Baltimore, Md.</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>University of Maryland Hospital</i>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>unknown</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>unknown</i>		
13a. STATE <i>Maryland</i>					13b. COUNTY <i>Baltimore</i>		13c. CITY OR TOWN <i>Baltimore</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <i>A. A. Gayland</i>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Marie Hall</i>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>unknown</i>					16b. SOCIAL SECURITY NO. <i>n.a.</i>		17. INFORMANT ADDRESS <i>Marie Hall, 1515 Mountmorris</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Cardiac Arrest</i> <i>4329</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Acute Renal Failure &amp; Uremia</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Brain Death &amp; Hypotension 2ery to massive Intracranial Bleed</i> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>2 days</i> <i>3 days</i>										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH <i>Alcoholic Liver Disease</i>										
19a. DATE OF OPERATION <i>None</i>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>None</i>				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) <i>None apparent</i>						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <i>Dec. 9, 1979</i> to <i>Dec. 9, 1979</i> , that (I) (we) last saw the deceased alive on <i>Dec. 9, 1979</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (do) view the body after death.										
22b. SIGNATURE <i>Arthur J. Komant</i>					22c. DATE SIGNED <i>12/9/79</i>			22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Arthur J. Komant</i>		
22e. ADDRESS <i>825. Greene St. Baltimore, Md.</i>										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>12-13-79</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Woodlawn Park</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Baltimore County</i>				
24. FUNERAL DIRECTOR NAME <i>Charles L. Glover</i>					25a. DATE REC'D. BY REGISTRAR <i>DEC 10 1979</i>		25b. REGISTRAR'S SIGNATURE <i>Robert McBrady</i>			





TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 30132					
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Norman (Fisher) Hall										2a. DATE OF DEATH KNOWN ESTIMATED 11 5 19 79		2b. HOUR M P			
3. SEX Male		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR 6 10 37		6. AGE (IN YEARS) LAST BIRTHDAY 42 YRS.		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN		2c. DATE PRONOUNCED DEAD MONTH DAY YEAR 11 5 19 79		2d. HOUR M P	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland				7b. CITIZEN OF WHAT COUNTRY? U. S. A.				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City, MD.			
10. CITY OR TOWN OF DEATH Baltimore				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1630 N. Wolfe Street				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY			
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)															
13a. STATE Maryland		13b. COUNTY		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 1630 North Wolfe Street							
14. FATHER'S NAME FIRST MIDDLE LAST James Fisher						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Beatrice Hall									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No				16b. SOCIAL SECURITY NO. 212-34-7080		17. INFORMANT ADDRESS Carolyn Tavers 6529 Loch Hill Road									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Undetermined</u> 7999 Conditions, if any, which gave rise to immediate cause (a) stating the <u>underlying</u> cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).															
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .															
ACTUAL SIGNATURE Virginia L. Dolan				TITLE (SPECIFY) Assistant				MEDICAL EXAMINER				DATE SIGNED 11/6/79			
EXAMINER'S NAME (TYPE OR PRINT) Virginia L. Dolan, M.D.				ADDRESS 111 Penn Street											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 11/10/79		23c. NAME OF CEMETERY OR CREMATORY Mt. Calvary Cemetery				23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Maryland					
24. FUNERAL DIRECTOR NAME Wm. C. March F/H 1101 East North Avenue						25a. DATE REC'D. BY REGISTRAR NOV 7 1979				25b. REGISTRAR'S SIGNATURE [Signature]					



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

79 30133

REG. NO.

1. FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) HELEN MARIE HAMEL			2a. DATE OF DEATH MONTH DAY YEAR 12 10 79		2b. HOUR 10:35am							
3 SEX FEMALE		4 RACE WHITE		5 DATE OF BIRTH MONTH DAY YEAR 01 18 97		6 AGE (IN YEARS (LAST BIRTHDAY)) 82 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS		8. IF UNDER 24 HRS HOURS MIN		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD						
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) ST. AGNES HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOMEMAKER			12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE MARYLAND			13b. COUNTY ---		13c. CITY OR TOWN BALTIMORE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 2922 BENSON AVENUE, 21223			
14. FATHER'S NAME FIRST MIDDLE LAST WILLIAM J. YOUNG SR.			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST LOTTIE GARDNER									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			16b. SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES) 213-54-0680		17. INFORMANT ADDRESS WILLIAM J. YOUNG, JR., 2922 BENSON AVENUE							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>CARDIO - PULMONARY ARREST</u> 486- Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>DUE TO, OR AS A CONSEQUENCE OF PNEUMONITIS RIGHT LUNG.</u> (c) <u>DUE TO, OR AS A CONSEQUENCE OF SEPSIS SECONDARY TO (b)</u>											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)												
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from <u>12/8/79</u> to <u>12/10/79</u> , that (I) (we) last saw the deceased alive on <u>12/10/79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE Y <u>Osei-Wusu</u>			DEGREE			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			22c. DATE SIGNED 12/10/79			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) A. OSEI-WUSU MD						22e. ADDRESS 900 CATON AVE. BALTIMORE MD 21229						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE 12-13-79		23c. NAME OF CEMETERY OR CREMATORY LOUDON PARK			23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE CITY MARYLAND				
24. FUNERAL DIRECTOR NAME HUBBARD FUNERAL HOME, INC., 4107 WILKENS AVE.			ADDRESS 21229			25a. DATE REC'D. BY REGISTRAR DEC 12 1979		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>				

MEDICAL CERTIFICATION

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1930 10 3



BALTIMORE CITY

ST. AGNES HOSPITAL

BALTIMORE

CHIEF - SURGEON GENERAL

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										7 9 3 0 1 3 4 REG. NO.		
1. FOR STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT) LEE — ELMER. HAMILTON				2a. DATE OF DEATH MONTH DAY YEAR December 27, 1979				2b. HOUR 3:15 AM		
3 SEX Female		4 RACE White		5 DATE OF BIRTH MONTH DAY YEAR October 24, 1891		6 AGE (IN YEARS LAST BIRTHDAY) 88 YRS.		7 IF UNDER 1 YEAR MONTHS DAYS		8 IF UNDER 24 HRS HOURS MIN		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.						
10 CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) ST. AGNES HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Home Maker			12b. KIND OF BUSINESS OR INDUSTRY Home			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) Maryland				13b. CITY Baltimore		13c. CITY OR TOWN Holifield		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 7941 Johnnycake Road 21207		
14. FATHER'S NAME FIRST MIDDLE LAST William B. Wood				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Caroline Talbott								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No				16b. SOCIAL SECURITY NO. 218-36-4007		17. INFORMANT ADDRESS A Mr. Robert Bruce Hamilton, Sr. 21207						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory arrest.</u> 586- DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Renal failure, Anemia.</u>												
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22. I certify that (I) (this hospital) attended the deceased from <u>12-26-79</u> , to <u>12-27-79</u> , that (I) (we) lost saw the deceased alive on <u>12-27-79</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE <u>G. C. Talbott</u>				DEGREE 170				ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 12-27-79		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) G. C. TALBOTT				22e. ADDRESS 900 CATON AVE. BALTIMORE, MD. 21229								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12/31/79		23c. NAME OF CEMETERY OR CREMATORY Lake View Memorial Park		23d. LOCATION CITY OR TOWN COUNTY STATE Sykesville Carroll MD						
24. FUNERAL DIRECTOR Loring Byers Funeral Directors 8728 Liberty Rd. Randallstown, Md. 21133						25a. DATE REC'D. BY REGISTRAR DEC 28 1979		25b. REGISTRAR'S SIGNATURE <u>Loring Byers</u>				



BALTIMORE CITY

ST. AGNES HOSPITAL

BALTIMORE

808 CATON AVE. BALTIMORE, MD. 21202

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR 1. STATE REGISTRAR		STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH		7 9 3 0 1 3 5 REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) <i>Pauline E. Hamilton</i>		2a. DATE OF DEATH MONTH DAY YEAR <i>12 22 79</i>		2b. HOUR <i>4 25</i> M	
3 SEX <i>Female</i>	4 RACE <i>Cauc.</i>	5. DATE OF BIRTH MONTH DAY YEAR <i>May 27, 1927</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>52</i> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Kentucky</i>	7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>BALTIMORE CITY</i> MD.	
10 CITY OR TOWN OF DEATH <i>Baltimore</i>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>THE JOHNS HOPKINS HOSPITAL</i>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Housewife</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Own Home</i>
13a. STATE <i>Maryland</i>	13b. COUNTY <i>P.G.</i>	13c. CITY OR TOWN <i>Bowie</i>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS <i>2512 Kennet Lane</i>	
14 FATHER'S NAME FIRST MIDDLE LAST <i>James M. Sinclair</i>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Mabel Berry</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>no</i>	16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <i>406-34-2052</i>	17. INFORMANT ADDRESS <i>Ladd E. Hamilton, 2512 Kennet La., Bowie, Md.</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Respiratory Failure</i> <i>1629</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Metastatic Lung Carcinoma</i> DUE TO, OR AS A CONSEQUENCE OF (c) _____					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (1) (this hospital) attended the deceased from <i>12-22</i> 19 <i>79</i> , to <i>12-22</i> 19 <i>79</i> , that (1) (we) last saw the deceased alive on <i>12-22</i> 19 <i>79</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <i>David Mishkin</i>		DEGREE <i>M.D.</i>		22c. DATE SIGNED <i>12/22/79</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>David Mishkin</i>		22e. ADDRESS <i>601 N. Broadway; Baltimore Md.</i>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>Dec. 27, 1979</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Resurrection Cemetery</i>	
23d. LOCATION CITY OR TOWN COUNTY STATE <i>Clinton, Maryland</i>		23e. DATE REC'D. BY REGISTRAR <i>JAN 1 1980</i>			
24. FUNERAL DIRECTOR NAME ADDRESS <i>Beall Funeral Home 9013 Annapolis Road, Lanham, Maryland</i>		25a. REGISTRAR'S SIGNATURE <i>[Signature]</i>			



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WASHINGTON CITY

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

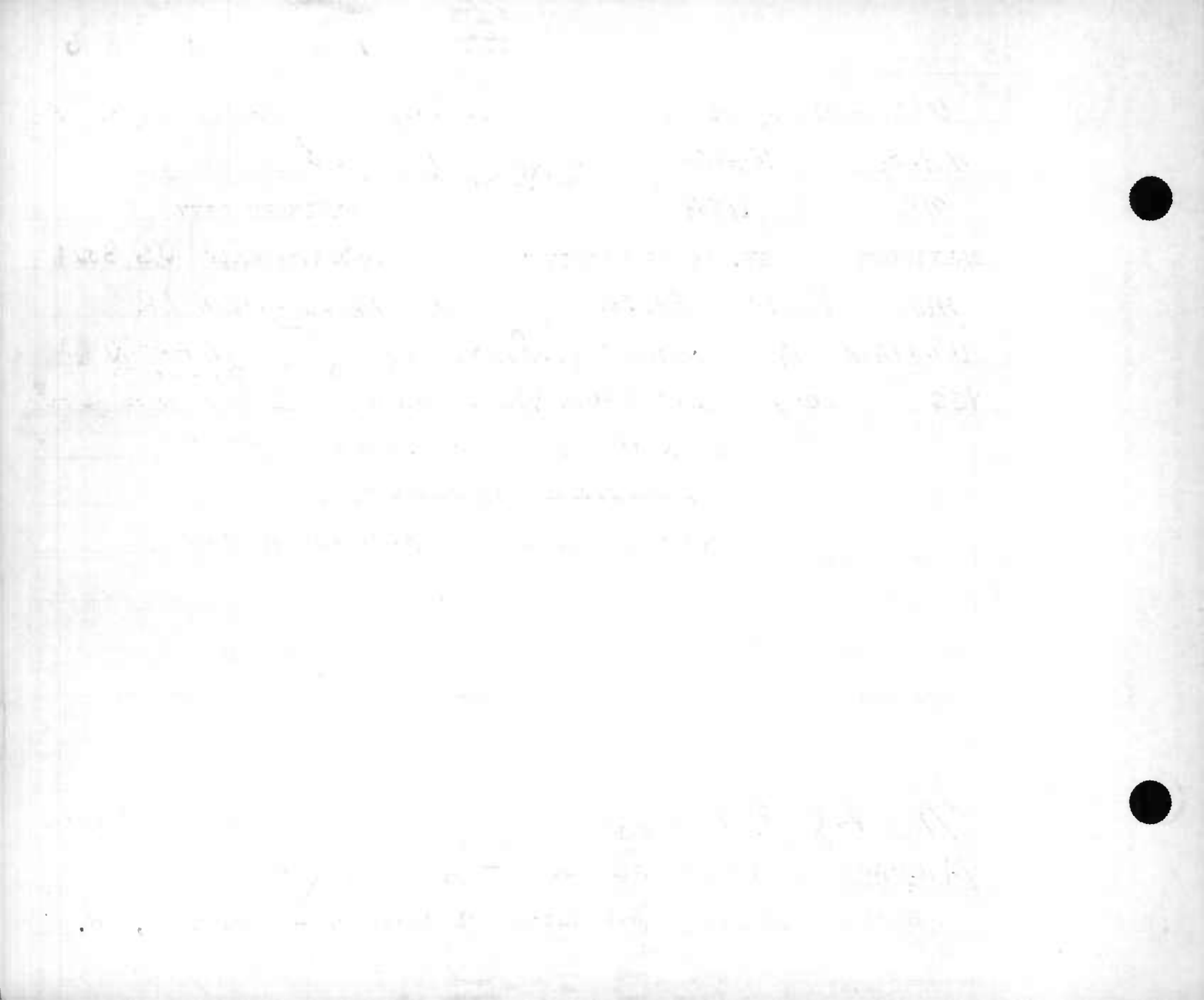
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

FOR 1- STATE REGISTRAR				STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				7 9 3 0 1 3 6 REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) WILLIAM RODGERS HAMILTON, Jr.				2a. DATE OF DEATH MONTH DAY YEAR 12-12-79				2b. HOUR 6:20 P.M.			
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH 3-27-11		6. AGE (IN YEARS LAST BIRTHDAY) 68 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS		8. IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.					
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) ST. AGNES HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Data Processor		12b. KIND OF BUSINESS OR INDUSTRY U.S. Govt.			
13a. STATE MD.				13b. CITY OR TOWN BALTO.		13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13d. STREET ADDRESS 116 Longview Dr			
14. FATHER'S NAME WILLIAM R. HAMILTON				15. MOTHER'S MAIDEN NAME R. ESTELLE (MARTIN)							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES				16b. SOCIAL SECURITY NO. 218-030036		17. INFORMANT Balto, Md. Wm. R. HAMILTON, III		ADDRESS 21230 1155 Riverside Ave			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BRONCHOPNEUMONIA, LOWER LOBES, SEVERE 4330 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) PONTINE INFARCTION (c) ATHEROSCLEROSIS BASILAR ARTERY APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Michael E. Pelczar MD				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c. DATE SIGNED 12/13/79			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) MICHAEL E. PELCZAR MD				22e. ADDRESS ST. AGNES HOSP							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 12/15/79		23c. NAME OF CEMETERY OR CREMATORY New Cathedral Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Md.			
24. FUNERAL DIRECTOR NAME Sterling Funeral Estate 736 Edmondson Ave. Catonsville, Md 21228						25a. DATE REC'D. BY REGISTRAR DEC 17 1979		25b. REGISTRAR'S SIGNATURE [Signature]			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the death certificate with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										7 9 3 0 1 3 7	
1- FOR STATE REGISTRAR										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) <b>JESSIE LOUIS HAMLETT</b>						2a. DATE OF DEATH MONTH DAY YEAR <b>12-16-79</b>			2b. HOUR <b>6 A M</b>		
3. SEX <b>MALE</b>		4. RACE <b>BLACK</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>JUNE 1, 1897</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>82</b> YRS		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>KEYSVILLE, VA.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE, CITY</b> MD.					
10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>JOHN DEATON NURSING HOME</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>BETH. STEEL</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>STEEL IND.</b>			
13a. STATE <b>MARYLAND</b>						13b. COUNTY <b>N/A</b>		13c. CITY OR TOWN <b>BALTIMORE</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>WILLIAM HAMLETT</b>						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>NANNIE BARKSDALE</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>YES</b>				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>WW I</b>		17. INFORMANT ADDRESS <b>MRS. EUGENIA MONROE 5 SOUTH ROSEDALE</b>					
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Aspiration Pneumonia</b> 496- DUE TO, OR AS, A CONSEQUENCE OF (b) <b>Chronic Pulmonary Disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS, A CONSEQUENCE OF (c) <b>Pneumonia Exacerbated by Stroke</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: <b>1 week</b> <b>Years</b> <b>2 years.</b>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): <b>Chronic Indwelling Foley &amp; Urinary Infection</b>											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) <del>(the hospital)</del> attended the deceased from <b>10-5</b> , 19 <b>79</b> , to <b>12-16</b> , 19 <b>79</b> , that (I) <del>(the hospital)</del> lost saw the deceased alive on <b>12-14</b> , 19 <b>79</b> , and that in (my) <del>(my)</del> opinion death occurred on the date and hour and from the causes stated above, (I) <del>(we)</del> did not view the body after death.											
22b. SIGNATURE <b>AG Zerbe MD</b>						DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>12-17-1979</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>JOSEPH W. ZERBLE III M.D.</b>						22e. ADDRESS <b>3809 Greenmount Ave BALTIMORE 21218</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>				23b. DATE <b>12-20-79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>ARBUTUS MEM. PK.</b>			23d. LOCATION CITY OR TOWN COUNTY STATE <b>ARBUTUS, MD.</b>		
24. FUNERAL DIRECTOR NAME <b>LEROY O. DYETT &amp; SON 4600 LIBERTY HGHTS. AV.</b>						25a. DATE REC'D. BY REGISTRAR <b>DEC 18 1979</b>		25b. REGISTRAR'S SIGNATURE <b>Robert M. Brady</b>			

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 30138

FOR 1- STATE REGISTRAR						DEPARTMENT OF HEALTH AND MENTAL HYGIENE <b>MEDICAL EXAMINER'S CERTIFICATE OF DEATH</b>						REG. NO. <b>30138</b>					
1. DECEASED NAME (TYPE OR PRINT) <b>James Hamm</b>						2a. DATE KNOWN OF DEATH ESTIMATED MONTH DAY YEAR <b>XX 12 22 1979</b>						2b. HOUR M <b>6:00A</b>					
3. SEX <b>Male</b>		4. RACE <b>Black</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>9 9 29</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>50 YRS.</b>		IF UNDER 1 YR. MONTHS DAYS <b>0 0</b>		IF UNDER 24 HRS. HOURS MIN. <b>0 0</b>		2c. DATE PRONOUNCED DEAD MONTH DAY YEAR <b>12 22 1979</b>		2d. HOUR M <b>6:00A</b>			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Honolulu Co., HI</b>				7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City, MD.</b>					
10. CITY OR TOWN OF DEATH <b>Baltimore City</b>				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Harbor Tunnel Thruway</b>						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Plasterer</b>				12b. KIND OF BUSINESS OR INDUSTRY			
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)						13a. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>						13b. STREET ADDRESS <b>3001 Arden Ave</b>					
13a. STATE <b>MD.</b>		13b. COUNTY <b>Prince Georges</b>		13c. CITY OR TOWN <b>New York</b>													
14. FATHER'S NAME FIRST MIDDLE LAST <b>Preston Hamm</b>						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Josephine Robinson</b>											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) IF YES, GIVE WAR OR DATES <b>NO</b>				16b. SOCIAL SECURITY NO. <b>249-44 7639</b>				17. INFORMANT ADDRESS <b>Josephine Hamm - 1404 W. Frazier ST</b>									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Blunt injury to head with atlanto-occipital separation</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).																	
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>5:29x 12 22 1979</b>				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) <b>pedestrian struck by auto</b>									
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <b>thruway</b>				21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b>Harbor Tunnel Thruway, Balto. City, MD.</b>									
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .																	
ACTUAL SIGNATURE <b>Virginia L. Dolan</b>				M.D. Assistant MEDICAL EXAMINER				DATE SIGNED <b>12/22/79</b>									
EXAMINER'S NAME (TYPE OR PRINT) <b>Virginia L. Dolan, M.D.</b>				ADDRESS <b>111 Penn St. Balto., MD.</b>													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>				23b. DATE <b>12/29/79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Sunset Mem. Gardens</b>				23d. LOCATION CITY OR TOWN COUNTY STATE <b>Flower Hill Baltimore B.C.</b>							
24. FUNERAL DIRECTOR NAME ADDRESS <b>Penick &amp; Sons 3197 Schaefer St</b>				25a. DATE REC'D. BY REGISTRAR <b>DEC 27 1979</b>				25b. REGISTRAR'S SIGNATURE <b>Rita K. Kennedy</b>									





8



FOR  
1 - STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

7 9 3 0 1 3 9  
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Anna Margaret Hanan			2a. DATE OF DEATH MONTH DAY YEAR December 13 1979			2b. HOUR 6:17 P.M.			
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR Dec 5 1919		6. AGE (IN YEARS LAST BIRTHDAY) 84 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.			
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Hamilton Nursing Center				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired		12b. KIND OF BUSINESS OR INDUSTRY Town Clerk	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md				13b. COUNTY Baltimore		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Frances Hanan				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Caroline Hubbard					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No				16b. SOCIAL SECURITY NO. 212-20-7109		17. INFORMANT ADDRESS Camline Schaerle 3929 Hudson St.			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CVA (recurrent) Cerebrovascular		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 12 hrs.	
4029 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (b) ASCVD - prior left hemiplegia		2 yrs	
DUE TO, OR AS A CONSEQUENCE OF (c) Hypertensive C-V disease			

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):  
Osteoarthritis

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from Aug 15, 1979, to Dec 13, 1979, that (I) (we) last saw the deceased alive on Dec 13, 1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Harold V. Harbold M.D. ATTENDING PHYSICIAN						22c. DATE SIGNED Dec. 14, 1979	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) HAROLD V. HARBOLD M.D.						22e. ADDRESS 4706 HARFORD Rd BALTIMORE Md 21214	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12-17-79		23c. NAME OF CEMETERY OR CREMATORY Baltimore Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore City Md	
24. FUNERAL DIRECTOR NAME ADDRESS Thelma A. Hoffmann 3218 Hudson St.				25a. DATE REC'D. BY REGISTRAR DEC 18 1979		25b. REGISTRAR'S SIGNATURE [Signature]	

35 90 35 300 1

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of 5  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

2609



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed in 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR  
1 - STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

7 9 30140

1. DECEASED NAME (TYPE OR PRINT) <b>EDWIN K. HANSSEN</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>12-11-79</b>			2b. HOUR <b>10<sup>10</sup> PM</b>			
3. SEX <b>MALE</b>		4. RACE <b>CAUCASIAN</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>8 16 24</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>55</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MD.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>CITY</b> MD.			
10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>2644 NORLAND RD.</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>TRUCK DRIVER</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>BALTO. G &amp; E</b>	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>MD.</b>		13b. COUNTY <b>---</b>		13c. CITY OR TOWN <b>BALTIMORE</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>2644 NORLAND RD.</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>WILLIAM HANSSEN</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>LILLIAN RENDALL</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>YES</b>		16b. SOCIAL SECURITY NO. <b>219-16-5160</b>		17. INFORMANT ADDRESS <b>GARY E. HANSSEN, 2644 NORLAND ROAD, 21230</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>HEPATIC FAILURE</b> <b>1991</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (b) <b>ADENOCARCINOMA METASTATIC TO LIVER (UNKNOWN PRIMARY)</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>---</b>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>4 WKS.</b> <b>6 WKS.</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>11-07 19 79</b>			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>11-07 19 79</b> to <b>12-07 19 79</b> , that (I) (we) last saw the deceased alive on <b>12-07 19 79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>Oscar E. Fernandini M.D.</b>			DEGREE <b>M.D.</b>			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>12-12-79</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>OSCAR E. FERNANDINI M.D.</b>			22e. ADDRESS <b>2025 W. FAYETTE ST. BALTO. MD. 21223</b>						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>			23b. DATE <b>12-15-79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>LOUDON PARK</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>BALTIMORE CITY MARYLAND</b>		
24. FUNERAL DIRECTOR NAME <b>HUBBARD FUNERAL HOME, INC.</b>			ADDRESS <b>4107 WILKENS AVE.</b>			25a. DATE REC'D. BY REGISTRAR <b>DEC 14 1979</b>		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>	

101 11-11-51

EDWIN K. HANSEN

STATE MARYLAND & DISTRICT OF COLUMBIA  
MD. USA  
CITY

PATIENCE 2214 HILFMAN RD.  
NO. 1 BALTIMORE

WILLIAM HANSEN  
RANDALL

HEALTH CARE  
ADMISSIONS

11-01-51 12-01-51

ORANGE E. FARMER MD.  
ORANGE E. FARMER MD. BOX 11 FAYETTE

DEC 11 1951

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at 1700.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		REG. NO. 9930141							
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH MONTH DAY YEAR	
Ollie		F.		Hardin		Hardin		12 28 79	
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR MONTHS DAYS	
M		B		7 23 15		64		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			
S.C.		USA				Balt. City MD.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Balt.		2713 E. Biddle St.							
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13b. CITY OR TOWN		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS			
Md		Balt.				2713 E. Biddle St.			
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST							
James		Hardin		Classie Meadow					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO		17. INFORMANT		ADDRESS			
Yes		WWII		248-12-7181		Gertrude Harden 2713 E. Biddle St.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY:								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (a) 185- Ca prostate									
DUE TO, OR AS A CONSEQUENCE OF (b)									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last									
DUE TO, OR AS A CONSEQUENCE OF (c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
		P.M. 19							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY STATE	
						79		79	
22a. I certify that (I) (this hospital) attended the deceased from 12/19/79 to 12/28/79, that (I) (we) lost now the deceased alive on 12/19/79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) not view the body after death.									
22b. SIGNATURE		DEGREE		22c. DATE SIGNED					
J. LEONARD LICHTENBERG		M.D.		1/2/80					
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS		22f. MEDICAL PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>					
J. LEONARD LICHTENBERG		2435 W. BELVEDERE AV BALTO MD 21215							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN		COUNTY STATE	
Burial		1/3/80		Baltimore Cem.		Baltimore Md.			
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Wm C March F/H		1101 E. North Ave.		JAN 3 1980		Anthony McCreedy			



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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				7 9 3 0 1 4 2			
1. FOR STATE REGISTRAR				REG. NO.			
1 DECEASED NAME (TYPE OR PRINT) <u>GERTRUDE M. HARGEST</u>				2a. DATE OF DEATH MONTH <u>DEC.</u> DAY <u>7</u> YEAR <u>1979</u>		2b. HOUR <u>M</u>	
3 SEX <u>F</u>		4 RACE <u>W</u>		5. DATE OF BIRTH MONTH <u>8</u> DAY <u>19</u> YEAR <u>76</u>		6 AGE (IN YEARS LAST BIRTHDAY) <u>83</u> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>MD</u>		7b. CITIZEN OF WHAT COUNTRY? <u>USA</u>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <u>Balto City</u> MD.	
10 CITY OR TOWN OF DEATH <u>Balto City</u>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>JEWISH CONValescent HOME</u>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>AT HOME</u>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <u>MD</u> 13a. COUNTY <u>Carroll</u> 13a. CITY OR TOWN <u>SKYERSVILLE</u>				13b. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13c. STREET ADDRESS <u>2816 Raywood Pl.</u>	
14 FATHER'S NAME FIRST <u>John</u> MIDDLE <u>T.</u> LAST <u>MS MAMEY</u>				15. MOTHER'S MAIDEN NAME FIRST <u>MARY</u> MIDDLE <u>BAUMILLER</u> LAST			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <u>NO</u>		16b. SOCIAL SECURITY NO. <u>213-05-7408</u>		17 INFORMANT ADDRESS <u>FAMILY RECORDS</u>			
11 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>4292</u> DUE TO, OR AS A CONSEQUENCE OF <u>CUA</u> (b) <u>ASCU</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>ASCU</u>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <u>P.M.</u> <u>19</u>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>1978</u> 19 <u>12</u> 7 <u>79</u> , that (I) (we) last saw the deceased alive on <u>11/26</u> 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>Wickson</u> DEGREE				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>12/10/79</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>WICKSON</u>				22e. ADDRESS <u>3502 W. Rogers</u>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		23b. DATE <u>12-11-79</u>		23c. NAME OF CEMETERY OR CREMATORY <u>CATHEDRAL CEM.</u>		23d. LOCATION CITY OR TOWN COUNTY STATE <u>Balto MD.</u>	
24 FUNERAL DIRECTOR NAME <u>EVANS FUNERAL CHAPEL</u> ADDRESS <u>8800 HARFORD RD</u>				25a. DATE REC'D. BY REGISTRAR <u>DEC 15 1979</u> 25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>			

BP

DHMH-16 20M  
(VRA 15, 4) 7/78





STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

30143

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR
1. DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST			
AMY L. HARPER						12-3-79 8:55 P.M.	
3 SEX	4 RACE	5 DATE OF BIRTH		6 AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR	
Female	Negro	MONTH DAY YEAR 4 13 1928		51 YRS.		IF UNDER 24 HRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH			
Maryland	U. S. A.			BALTIMORE CITY MD.			
10 CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT CITY OR TOWN)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		
Baltimore	JOHN'S HOPKINS HOSPITAL						
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13a. STATE		13b. COUNTY		13c. CITY OR TOWN	
		Maryland				Baltimore	
14 FATHER'S NAME		15. MOTHER'S MAIDEN NAME		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS	
FIRST MIDDLE LAST Joseph Harper		FIRST MIDDLE LAST Catherine Hughes		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		3401 Garrison Boulevard	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17 INFORMANT		ADDRESS	
		212-22-4191		Allen E. Harper		3401 Garrison Boulevard	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>CARDIO-Respiratory Arrest</u>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Severe Physical Debilitation</u>							6 Months
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Metastatic Carcinoma of the Cervix</u>							4 years
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
				YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>Nov 5</u> , 19 <u>79</u> , to <u>Dec 3</u> , 19 <u>79</u> , that (I) (we) lost saw the deceased alive on <u>Dec 3</u> , 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE		DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED	
<u>John T. Repke, MD</u>						12/4/79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS					
JOHN T. REPKE		Johns Hopkins Hospital					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE	
Burial		12/10/1979		Mount Auburn Cemetery		Baltimore, Maryland	
24 FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
NAME Wm. C. March F/H 1101 East North Avenue		DEC 6 1979		<u>John T. Repke</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be retained by the funeral director with the State Department of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of this.

RECEIVED  
JAN 11 1950  
2 10 03 51

CVJ3M

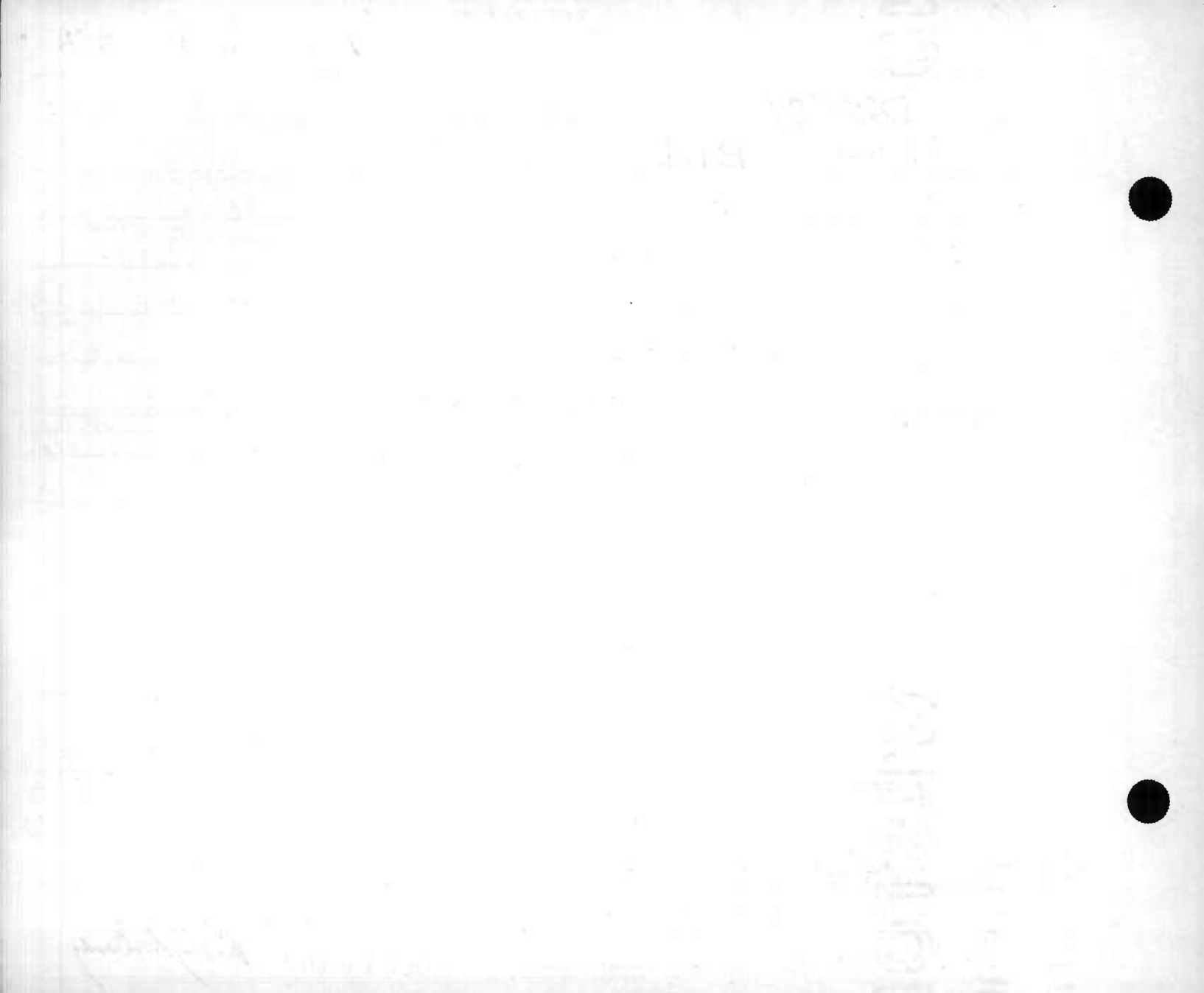
DATE	TIME	FROM	TO	SUBJECT
12-15-49	10:00	WASH DC	NEW YORK	RE: [illegible]
12-15-49	10:05	NEW YORK	WASH DC	RE: [illegible]
12-15-49	10:10	NEW YORK	WASH DC	RE: [illegible]
12-15-49	10:15	NEW YORK	WASH DC	RE: [illegible]
12-15-49	10:20	NEW YORK	WASH DC	RE: [illegible]
12-15-49	10:25	NEW YORK	WASH DC	RE: [illegible]
12-15-49	10:30	NEW YORK	WASH DC	RE: [illegible]
12-15-49	10:35	NEW YORK	WASH DC	RE: [illegible]
12-15-49	10:40	NEW YORK	WASH DC	RE: [illegible]
12-15-49	10:45	NEW YORK	WASH DC	RE: [illegible]
12-15-49	10:50	NEW YORK	WASH DC	RE: [illegible]
12-15-49	10:55	NEW YORK	WASH DC	RE: [illegible]
12-15-49	11:00	NEW YORK	WASH DC	RE: [illegible]
12-15-49	11:05	NEW YORK	WASH DC	RE: [illegible]
12-15-49	11:10	NEW YORK	WASH DC	RE: [illegible]
12-15-49	11:15	NEW YORK	WASH DC	RE: [illegible]
12-15-49	11:20	NEW YORK	WASH DC	RE: [illegible]
12-15-49	11:25	NEW YORK	WASH DC	RE: [illegible]
12-15-49	11:30	NEW YORK	WASH DC	RE: [illegible]
12-15-49	11:35	NEW YORK	WASH DC	RE: [illegible]
12-15-49	11:40	NEW YORK	WASH DC	RE: [illegible]
12-15-49	11:45	NEW YORK	WASH DC	RE: [illegible]
12-15-49	11:50	NEW YORK	WASH DC	RE: [illegible]
12-15-49	11:55	NEW YORK	WASH DC	RE: [illegible]
12-15-49	12:00	NEW YORK	WASH DC	RE: [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										79 30144	
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH		MONTH DAY YEAR	
DOROTHY		G.		HARPER				12		09 79	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR		8. IF UNDER 24 HRS	
FEMALE		Black		1 12 1931		48		MONTHS DAYS		HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH				MD.	
Maryland		U.S. A.				Baltimore City					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY					
Baltimore		Bon Secour Hospital									
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS			
Maryland				Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		323 North Fulton Avenue			
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS	
Louis		Dora				213-36-3539		Louis R. Harper		323 North Fulton Avenue	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)	
PART I. DEATH WAS CAUSED BY:		PART I. DEATH WAS CAUSED BY:		PART I. DEATH WAS CAUSED BY:		PART I. DEATH WAS CAUSED BY:		PART I. DEATH WAS CAUSED BY:		PART I. DEATH WAS CAUSED BY:	
IMMEDIATE CAUSE (a)		IMMEDIATE CAUSE (a)		IMMEDIATE CAUSE (a)		IMMEDIATE CAUSE (a)		IMMEDIATE CAUSE (a)		IMMEDIATE CAUSE (a)	
436- Cerebral Vascular Accident		436- Cerebral Vascular Accident		436- Cerebral Vascular Accident		436- Cerebral Vascular Accident		436- Cerebral Vascular Accident		436- Cerebral Vascular Accident	
DUE TO, OR AS A CONSEQUENCE OF		DUE TO, OR AS A CONSEQUENCE OF		DUE TO, OR AS A CONSEQUENCE OF		DUE TO, OR AS A CONSEQUENCE OF		DUE TO, OR AS A CONSEQUENCE OF		DUE TO, OR AS A CONSEQUENCE OF	
Hypertension		Hypertension		Hypertension		Hypertension		Hypertension		Hypertension	
DUE TO, OR AS A CONSEQUENCE OF		DUE TO, OR AS A CONSEQUENCE OF		DUE TO, OR AS A CONSEQUENCE OF		DUE TO, OR AS A CONSEQUENCE OF		DUE TO, OR AS A CONSEQUENCE OF		DUE TO, OR AS A CONSEQUENCE OF	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):		PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):		PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):		PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):		PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):		PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?					
				YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
		HOUR A.M. MONTH DAY YEAR									
		P.M. 19									
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION		CITY OR TOWN		COUNTY		STATE	
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				STREET		12/9 79		12/9 79			
22a. I certify that (I) (this hospital) attended the deceased from		22a. I certify that (I) (this hospital) attended the deceased from		22a. I certify that (I) (this hospital) attended the deceased from		22a. I certify that (I) (this hospital) attended the deceased from		22a. I certify that (I) (this hospital) attended the deceased from		22a. I certify that (I) (this hospital) attended the deceased from	
saw the deceased alive on		saw the deceased alive on		saw the deceased alive on		saw the deceased alive on		saw the deceased alive on		saw the deceased alive on	
above, (I) (did) (did not) view the body after death.		above, (I) (did) (did not) view the body after death.		above, (I) (did) (did not) view the body after death.		above, (I) (did) (did not) view the body after death.		above, (I) (did) (did not) view the body after death.		above, (I) (did) (did not) view the body after death.	
22b. SIGNATURE		22b. SIGNATURE		22b. SIGNATURE		22b. SIGNATURE		22b. SIGNATURE		22b. SIGNATURE	
Kuang-yen Huang		Kuang-yen Huang		Kuang-yen Huang		Kuang-yen Huang		Kuang-yen Huang		Kuang-yen Huang	
22c. PHYSICIAN'S NAME (TYPE OR PRINT)		22c. PHYSICIAN'S NAME (TYPE OR PRINT)		22c. PHYSICIAN'S NAME (TYPE OR PRINT)		22c. PHYSICIAN'S NAME (TYPE OR PRINT)		22c. PHYSICIAN'S NAME (TYPE OR PRINT)		22c. PHYSICIAN'S NAME (TYPE OR PRINT)	
HUANG KUANG-YEN		HUANG KUANG-YEN		HUANG KUANG-YEN		HUANG KUANG-YEN		HUANG KUANG-YEN		HUANG KUANG-YEN	
22d. ADDRESS		22d. ADDRESS		22d. ADDRESS		22d. ADDRESS		22d. ADDRESS		22d. ADDRESS	
Bon Secours Hospital 21223		Bon Secours Hospital 21223		Bon Secours Hospital 21223		Bon Secours Hospital 21223		Bon Secours Hospital 21223		Bon Secours Hospital 21223	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION		CITY OR TOWN		COUNTY STATE	
Burial		12/13/1979		Cedar Hill Cemetery		Anne Arundel Co.				Maryland	
24. FUNERAL DIRECTOR		24. FUNERAL DIRECTOR		24. FUNERAL DIRECTOR		24. FUNERAL DIRECTOR		24. FUNERAL DIRECTOR		24. FUNERAL DIRECTOR	
Wm. C. March F/H 1101 East North Avenue		Wm. C. March F/H 1101 East North Avenue		Wm. C. March F/H 1101 East North Avenue		Wm. C. March F/H 1101 East North Avenue		Wm. C. March F/H 1101 East North Avenue		Wm. C. March F/H 1101 East North Avenue	
25a. DATE REC'D. BY REGISTRAR		25a. DATE REC'D. BY REGISTRAR		25a. DATE REC'D. BY REGISTRAR		25a. DATE REC'D. BY REGISTRAR		25a. DATE REC'D. BY REGISTRAR		25a. DATE REC'D. BY REGISTRAR	
DEC 10 1979		DEC 10 1979		DEC 10 1979		DEC 10 1979		DEC 10 1979		DEC 10 1979	



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DHMH - 16 50M 1/76  
(VR A 15 (4))



1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

7 9 3 0 1 4 5

1. DECEASED NAME (TYPE OR PRINT) <b>Joneather</b>			2a. DATE OF DEATH MONTH <b>12</b> DAY <b>3</b> YEAR <b>79</b>			2b. HOUR <b>M</b>			
3. SEX <b>Fe Male</b>		4. RACE <b>B</b>		5. DATE OF BIRTH MONTH <b>4</b> DAY <b>2</b> YEAR <b>21</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>58</b> YRS		7. IF UNDER 1 YEAR MONTHS <b>0</b> DAYS <b>0</b> HOURS <b>0</b> MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>N.C.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.			
10. CITY OR TOWN OF DEATH <b>Balto.</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>2706 W. North Avenue</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE <b>Md.</b>		13b. COUNTY <b>Balto.</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>2706 W. North Ave.</b>			
14. FATHER'S NAME FIRST <b>John</b> MIDDLE <b>Collins</b> LAST <b>Collins</b>				15. MOTHER'S MAIDEN NAME FIRST <b>Nora</b> MIDDLE <b>Simms</b> LAST <b>Simms</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>				16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <b>George Collins 5119 Pembridge Ave.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>ACUTE MYOCARDIAL Infarction</b> <b>410-</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ (c) _____ DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Instantaneous</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>MARCH</b> 19 <b>79</b> , to <b>December</b> 19 <b>79</b> , that (I) (we) lost saw the deceased alive on <b>OCTOBER</b> 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>D. Beard, MD</b>				DEGREE <b>MD</b> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED <b>12/5/79</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>D. BEARD, MD</b>				22e. ADDRESS <b>Maryland General Hosp.</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>12/7/79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Arbutus Mem. Pk.</b>		23d. LOCATION CITY OR TOWN <b>Arbutus, Md.</b> COUNTY STATE			
24. FUNERAL DIRECTOR NAME <b>Wm C March F/H</b> ADDRESS <b>1101 E. North Ave.</b>				25a. DATE REC'D. BY REGISTRAR <b>DEC 6 1979</b>		25b. REGISTRAR'S SIGNATURE <b>History McCreedy</b>			

CHIEF  
12-10-80



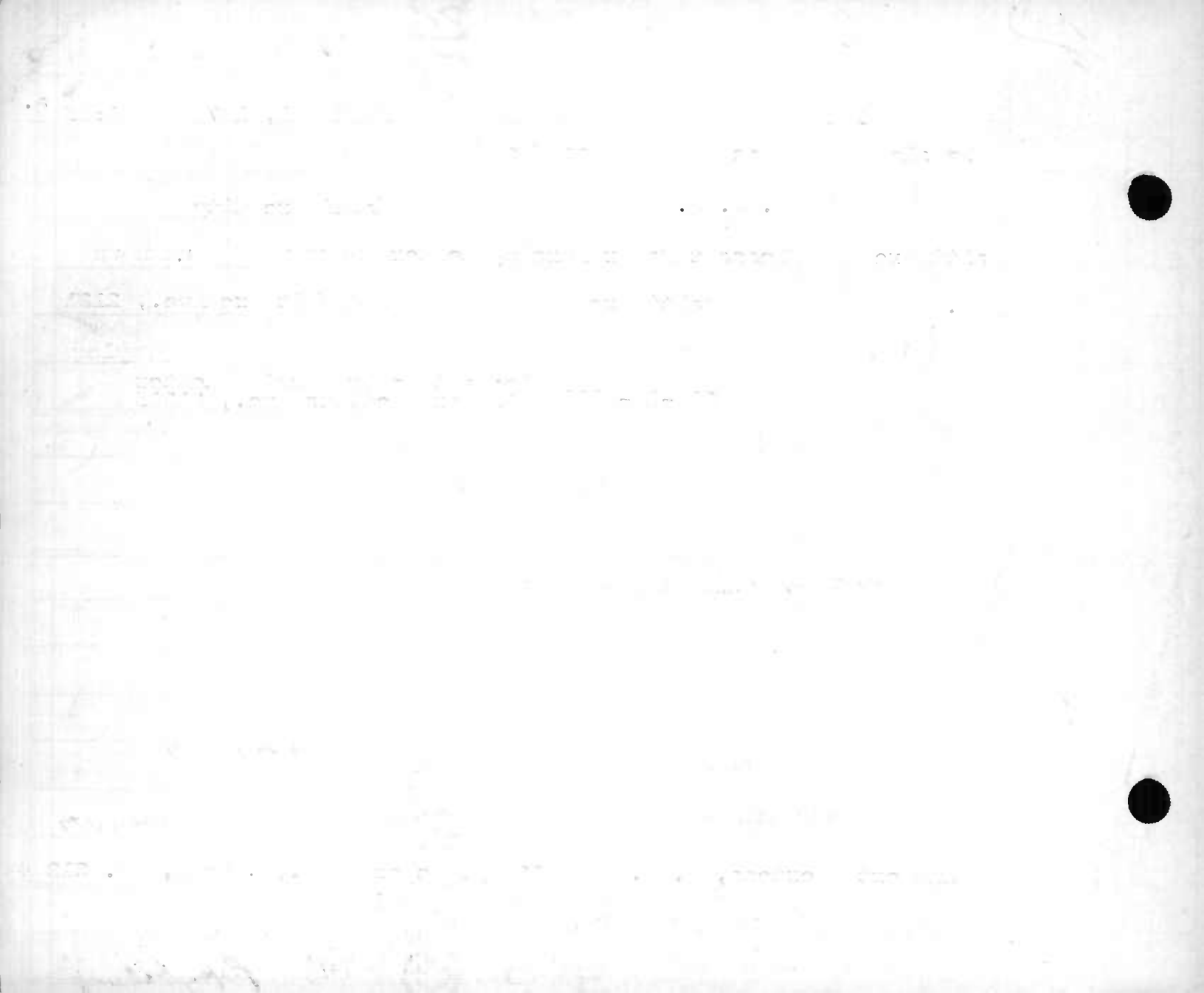


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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										7 9 3 0 1 4 6 REG. NO.		
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>CORA HARRIS</b>					2a. DATE OF DEATH MONTH DAY YEAR <b>JUNE 1, 1979</b>			2b. HOUR <b>1:45 a.m.</b>				
3. SEX <b>Female</b>		4. RACE <b>Black</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>11 / 20 / 84</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>94</b> YRS		7. IF UNDER 1 YEAR MONTHS DAYS <b>0 0</b>		8. IF UNDER 24 HRS HOURS MIN <b>0 0</b>		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Virginia</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD						
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Pleasant Manor Nursing Center</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>unknown</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>unknown</b>				
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Md.</b>					13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Baltimore</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>604 Whitmore Ave., 21216</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Samuel Lee</b>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Mildred Taylor</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)					16b. SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES) <b>219-16-5111</b>		17. INFORMANT ADDRESS <b>Pleasant Manor Nursing Center 4615 Park Heights Ave., 21215</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardio-Pulmonary Failure</b> <b>4289</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Advanced Senility.</b> DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): <b>Fracture Hip, Pitting - Deformities Strain.</b>												
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from <b>Dec 1973</b> , 19____, to <b>Aug 1979</b> , 19____, that (I) (we) last saw the deceased alive on <b>May 23</b> , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE <b>Humberto Certeza</b>					DEGREE <b>Attending Physician</b>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>June 1, 1979</b>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Humberto Certeza, M. D.</b>					22e. ADDRESS <b>1206 Goucher Blvd., Towson, Md. 21204</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>June 5, 79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Arbutus Mem. Park</b>			23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore County Md.</b>				
24. FUNERAL DIRECTOR NAME <b>Herbert E. Nutter</b>					ADDRESS <b>3035 W. North Ave.</b>		25a. DATE REC'D. BY REGISTRAR <b>JUN 4 1979</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>			



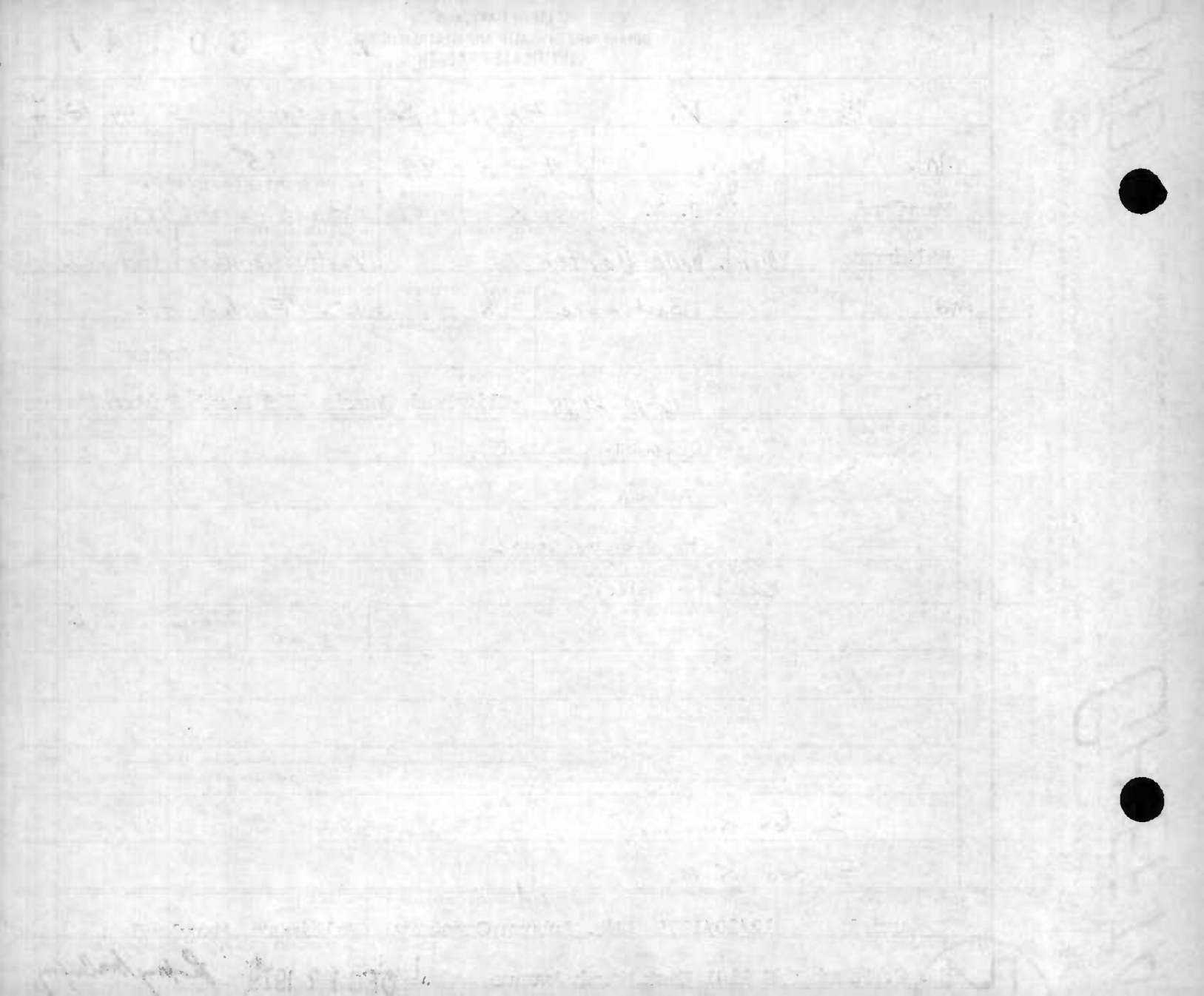
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										
1- FOR STATE REGISTRAR					7 9 3 0 1 4 7 REG. NO.					
1. DECEASED NAME (TYPE OR PRINT) Merris V. HARRIS, Sr.					2a. DATE OF DEATH MONTH DAY YEAR December 15 1979					2b. HOUR 12:40 AM
3 SEX Male		4 RACE Negro		5. DATE OF BIRTH MONTH DAY YEAR 4-3-94		6. AGE (IN YEARS LAST BIRTHDAY) 85 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.				
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Montebello Center				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Construction Worker		12b. KIND OF BUSINESS OR INDUSTRY Retired		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md.					13b. COUNTY		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Jackson					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) [IF YES, GIVE WAR OR DATES] No					16b. SOCIAL SECURITY NO. 216-10-8079		17. INFORMANT ADDRESS Elizabeth Harris 1529 North Fulton Avenue			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory arrest 436- DUE TO, OR AS A CONSEQUENCE OF (b) Asthma DUE TO, OR AS A CONSEQUENCE OF (c) Bulbular stroke APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) decubitus ulcer.										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE Euisoo Kim md				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 12-15-79		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Euisoo Kim.				22e. ADDRESS						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12/20/1979		23c. NAME OF CEMETERY OR CREMATORY Mt. Auburn Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Maryland				
24. FUNERAL DIRECTOR NAME Wm. C. March F/H 1101 East North Avenue				ADDRESS		25a. DATE REC'D. BY REGISTRAR DEC 17 1979		25b. REGISTRAR'S SIGNATURE Rafaela Brady		



2



DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										
1. FOR STATE REGISTRAR		REG. NO. 7 9 3 0 1 4 8								
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Sedonia Harris</i>					2a. DATE OF DEATH MONTH DAY YEAR <i>12 14 79</i>		2b. HOUR <i>12<sup>25</sup></i> M			
3. SEX <i>Female</i>		4. RACE <i>Negro</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>Feb. 18 1889</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>90</i> YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Maryland</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Baltimore City</i> MD.				
10. CITY OR TOWN OF DEATH <i>Baltimore</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Baltimore City Hospital</i>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Domestic</i>		12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE <i>Maryland</i>					13b. COUNTY		13c. CITY OR TOWN <i>Baltimore</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <i>Leonard Harris</i>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Lucy Fisher</i>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <i>N/A</i>		17. INFORMANT ADDRESS <i>Joseph Harris 1049 W. Fayette St.</i>						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiopulmonary arrest</i> <i>5183</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Lung Infiltration</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ DUE TO, OR AS A CONSEQUENCE OF									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a)										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <i>19</i>			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <i>D Siegel MD</i>			DEGREE			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			22c. DATE SIGNED <i>12/14/79</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>DSiegel</i>			22e. ADDRESS <i>Baltimore City Hospitals</i>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>			23b. DATE <i>19 Dec 79</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Mt. ZION Cemetery</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Baltimore Maryland</i>			
24. FUNERAL DIRECTOR NAME <i>Powell F/H</i>			ADDRESS <i>319 N. Schroeder Street</i>			25a. DATE REC'D. BY REGISTRAR <i>DEC 20 1979</i>		25b. REGISTRAR'S SIGNATURE <i>L. P. H. H. H.</i>		

1802 BP



Handwritten signature or initials.

1970 0 2 270

1970 0 2 270

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH																	
1. FOR STATE REGISTRAR		7 9 3 0 1 4 9				REG. NO.											
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH		MONTH		DAY		YEAR		2b. HOUR	
Howard E. Harrison								12/23/79								3:55 AM	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR		8. IF UNDER 24 HRS.		9. IF UNDER 1 YEAR		10. IF UNDER 24 HRS.			
male		Negro		11 22 52		27		YEARS		MONTHS		DAYS		HOURS		MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH										MD.	
md.		USA				Baltimore City											
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY											
Baltimore City		North Charles General Hospital		unemployed		-											
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS									
md.				Baltimore				2327 Barclay St									
14. FATHER'S NAME FIRST		MIDDLE		LAST		15. MOTHER'S MAIDEN NAME FIRST		MIDDLE		LAST							
James		T.		Harrison		Mary		Alice		Wilson							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES)		17. INFORMANT ADDRESS													
no		217569719		patient-Howard E Harrison - same as above													
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cirrhosis of Liver with</u> <u>5715</u> DUE TO, OR AS A CONSEQUENCE OF <u>upper G.I. Bleeding</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost } (b) <u>and Hepatic coma</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Hemorrhagic edema of lungs, liver</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): <u>Acute Renal Failure with Hypertension</u>																	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>											
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)													
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE							
22a. I certify that (I) (this hospital) attended the deceased from <u>12/23</u> 19 <u>79</u> to <u>12/23</u> 19 <u>79</u> , that (I) (we) lost the deceased alive on <u>12/23</u> 19 <u>79</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (we) (did) (did not) view the body after death.																	
22b. SIGNATURE		DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED											
MARCO B. GALICIA		MD				12/23/79											
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS															
MARCO B. GALICIA		1101 E. North Ave.															
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN		COUNTY		STATE							
Burial		12/27/79		Mt. Calvary Cem.		Anne Arundel Co.		Md.									
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE											
Wm C March E/H		1101 E. North Ave.		DEC 28 1979		[Signature]											



1914

1914

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 and 5 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

9 30150

1. FOR STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT)		FIRST Earl	MIDDLE A	LAST Hart	2a. DATE OF DEATH	MONTH 12	DAY 16	YEAR 79	2b. HOUR 5:25 P.M.
3. SEX M	4. RACE B	5. DATE OF BIRTH		MONTH 4	DAY 23	YEAR '84	6. AGE (IN YEARS LAST BIRTHDAY)	85		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Balto.	7b. CITIZEN OF WHAT COUNTRY? Md. USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Balto. MD.							
10. CITY OR TOWN OF DEATH Balto.	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Mercy Hospital					12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) RETIRED		12b. KIND OF BUSINESS INDUSTRY U. S. POST			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)						13a. STREET ADDRESS		13b. CITY OR TOWN			
13a. STATE B-Md.		13b. COUNTY		13c. CITY OR TOWN Balto.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 301 McMechen St.			
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. 212 40 2853		17. INFORMANT ADDRESS MRS. IDA HART 301 Mc Mechen Street			
14. FATHER'S NAME FIRST William		15. MOTHER'S MAIDEN NAME FIRST Rose		16a. YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> WW I		16b. SOCIAL SECURITY NO. 212 40 2853		17. INFORMANT ADDRESS MRS. IDA HART 301 Mc Mechen Street			
16a. YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> WW I		16b. SOCIAL SECURITY NO. 212 40 2853		17. INFORMANT ADDRESS MRS. IDA HART 301 Mc Mechen Street		18. CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
18. CAUSE OF DEATH		PART I. DEATH WAS CAUSED BY:		IMMEDIATE CAUSE (a)		DUE TO, OR AS A CONSEQUENCE OF		DUE TO, OR AS A CONSEQUENCE OF			
1889		Respiratory Arrest		DUE TO, OR AS A CONSEQUENCE OF		Metastatic Cancer of Bladder		10 min.			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		(b)		(c)		DUE TO, OR AS A CONSEQUENCE OF		months			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION 11/28/79		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Mass in back.		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (this hospital) attended the deceased from 11/16/79, 19, to 12/16/79, 19, that (we) last saw the deceased alive on 12/16/79, 19, and that in my opinion death occurred on the date and hour and from the causes stated above. (We did not view the body after death.)		22b. SIGNATURE Adam Bilet		DEGREE MD		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 12/16/79			
22a. I certify that (this hospital) attended the deceased from 11/16/79, 19, to 12/16/79, 19, that (we) last saw the deceased alive on 12/16/79, 19, and that in my opinion death occurred on the date and hour and from the causes stated above. (We did not view the body after death.)		22b. SIGNATURE Adam Bilet		DEGREE MD		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 12/16/79			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Adam Bilet		22e. ADDRESS Mercy Hosp.		23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 12/20/79		23c. NAME OF CEMETERY OR CREMATORY ST. THOMAS CEMETERY		23d. LOCATION CITY OR TOWN RANDALLSTOWN (BALTO.) MD.	
24. FUNERAL DIRECTOR NAME LEWIS T. GWYNN		4517 PARK HEIGHTS AVENUE		25a. DATE REC'D. BY REGISTRAR DEC 18 1979		25b. REGISTRAR'S SIGNATURE L. T. Gwynn					



U. S. POST

POSTAGE

YES 1 212 NO 2523 AND THE FIRST 301 to receive first

NOV 12/20/72 ST. THOMAS VICTORIA (HAWAII) MD.

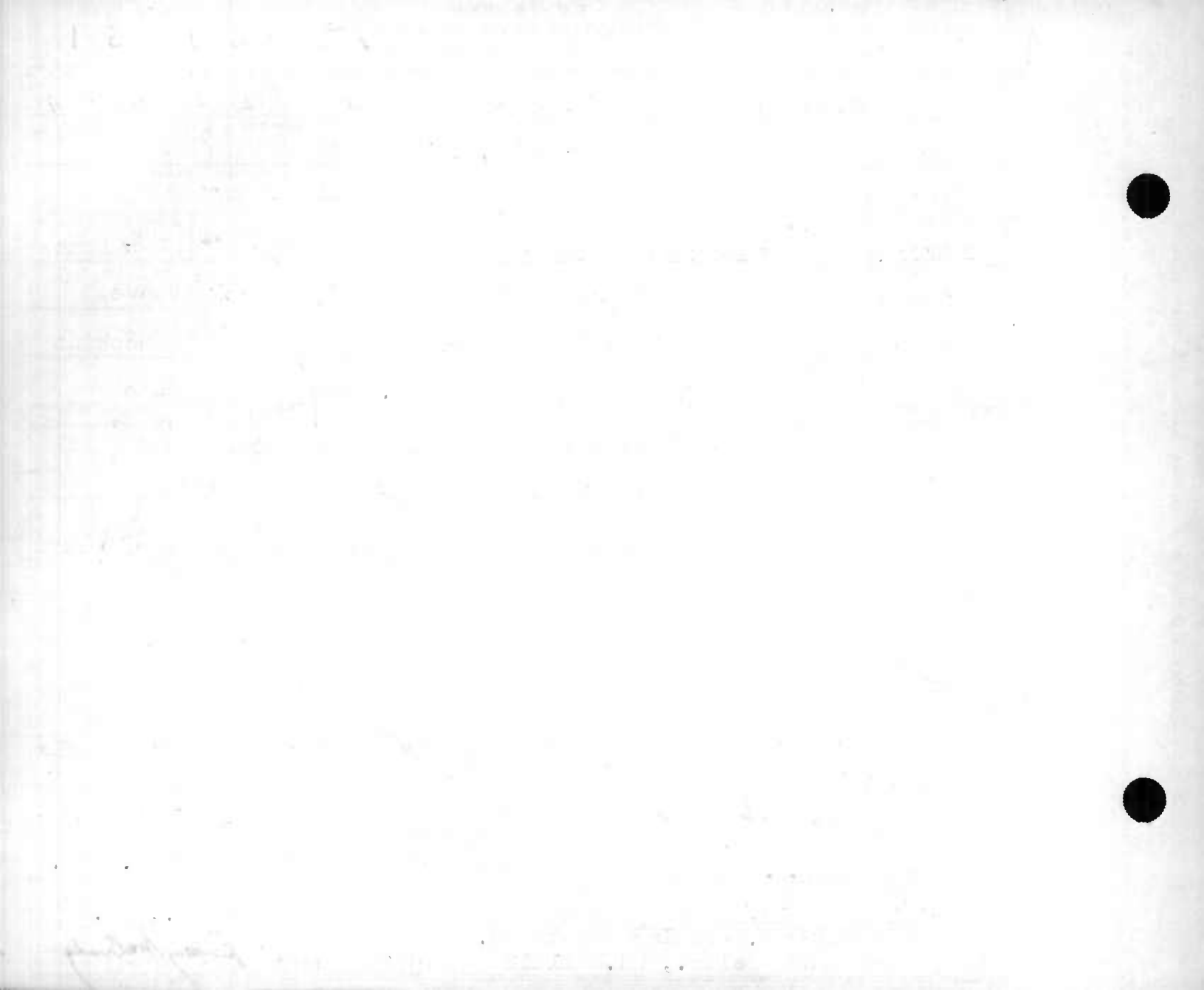
LEWIS T. CHINN 4517 PINE HILLS DRIVE

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 30151				
1. DECEASED NAME (TYPE OR PRINT)		FIRST MARGARET		MIDDLE		LAST HARVEY		2a. DATE OF DEATH		MONTH 12	DAY 20	YEAR 79	2b. HOUR 350	4M
3 SEX Female		4 RACE White		5. DATE OF BIRTH MONTH DAY YEAR April 17, 1894		6 AGE (IN YEARS LAST BIRTHDAY) 85		7. IF UNDER 1 YEAR MONTHS		8. IF UNDER 24 HRS DAYS		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY Own Home				
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) UNION MEMORIAL HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY Own Home								
13a. STATE Maryland		13b. COUNTY		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 2402 Hemlock Avenue						
14. FATHER'S NAME FIRST John		MIDDLE		LAST Williams		15. MOTHER'S MAIDEN NAME FIRST Sarah		MIDDLE		LAST Hopkins				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 215 72 0003		17. INFORMANT William H. Harvey		ADDRESS Same								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia 430- DUE TO, OR AS A CONSEQUENCE OF (b) Subarachnoid hemorrhage DUE TO, OR AS A CONSEQUENCE OF (c)													APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)														
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)										
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE										
22a. I certify that (I) (this hospital) attended the deceased from 12/9, 1979, to 12/20, 1979, that (I) (we) saw the deceased alive on 12/20, 1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.														
22b. SIGNATURE Alan Gaby, MD		DEGREE				ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c. DATE SIGNED 12/20/79				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ALAN GABY M.D.		22e. ADDRESS UNION MEMORIAL HOSPITAL Balto., Md.												
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12/22/79		23c. NAME OF CEMETERY OR CREMATORY Parkwood Cemetery		23d. LOCATION CITY OR TOWN Baltimore		COUNTY Co.,		STATE Md.				
24. FUNERAL DIRECTOR Henry W. Jenkins & Sons Co. NAME ADDRESS 4905 York Road Balto., Md. 21212						25a. DATE REC'D. BY REGISTRAR DEC 21 1979		25b. REGISTRAR'S SIGNATURE R. J. [Signature]						



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

7 9 3 0 1 5 2

REG. NO.

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST	11 1 79			4:55 a.m.
3. SEX Male		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR 11 01 10		6. AGE (IN YEARS LAST BIRTHDAY) 168 YRS		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Jamaica		7b. CITIZEN OF WHAT COUNTRY? ✓		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Balto. City MD.		
10. CITY OR TOWN OF DEATH Balto. City		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Mercy Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired		12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE 2000 O'dell Ave Maryland		13b. COUNTY Balto. City		13c. CITY OR TOWN Balto. City		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST James Harvey		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lizzie Robinson		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. 213-07-8485		
17. INFORMANT		ADDRESS						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY 1629 IMMEDIATE CAUSE (a) Metastatic lung carcinoma DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) Lung carcinoma DUE TO, OR AS A CONSEQUENCE OF (d) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH diagnosed 2/79 diagnosed 2/79						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from 9/30, 19 79, to 11/1, 19 79, that (we) lost saw the deceased alive on 10/31, 19 79, and that in my (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE Dr. Schulz		DEGREE MD		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 11/1/79		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Jeffrey Schuldenfrei M.D.		22e. ADDRESS Mercy Hospital		22f. ADDRESS Calvert St. Balto.				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Removal		23b. DATE 11/6/79		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE		
24. FUNERAL DIRECTOR NAME Anatomy Board		ADDRESS Balto., Md.		25a. DATE REC'D. BY REGISTRAR NOV 09 1979		25b. REGISTRAR'S SIGNATURE [Signature]		

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Report may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers, Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.



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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITH VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 30153	
1. DECEASED NAME (TYPE OR PRINT) <b>George Haske</b>						2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR <b>12 13 19 79</b>		2b. HOUR <b>M</b>			
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>March 19, 1900</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>79</b> YRS.		7. IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		7c. DATE PRONOUNCED DEAD <b>12 13 19 79</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>			7b. CITIZEN OF WHAT COUNTRY? <b>United States</b>			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City,</b> MD.		
10. CITY OR TOWN OF DEATH <b>Baltimore City</b>			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Church Home &amp; Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Clerk</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>Can Co.</b>	
13a. STATE <b>Maryland</b>						13b. COUNTY <b>-----</b>		13c. CITY OR TOWN <b>Baltimore</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET ADDRESS <b>226 N. Patterson Park Ave.</b>											
14. FATHER'S NAME FIRST MIDDLE LAST <b>Bernard J. Haske</b>						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Barbara - Herold</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>Yes</b>			16b. SOCIAL SECURITY NO. <b>W.W. IL 215-05-5822</b>			17. INFORMANT ADDRESS <b>Anna Driscoll 6036 Carter Ave. 21214</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic cardiovascular disease</b> <b>4292</b> Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ DUE TO, OR AS A CONSEQUENCE OF										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that I took charge of the remains described above, held an autopsy <input type="checkbox"/> , inspection <input checked="" type="checkbox"/> , inquiry <input type="checkbox"/> , and in my opinion death resulted from: <b>Natural causes</b> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE <b>Thomas D. Smith</b>				TITLE (SPECIFY) <b>Deputy Chief</b>				DATE SIGNED <b>12/14/79</b>			
EXAMINER'S NAME (TYPE OR PRINT) <b>Thomas D. Smith, M.D.</b>				ADDRESS <b>111 Penn St. Balto., MD.</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>				23b. DATE <b>Dec. 17, 1979</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Holy Redeemer Cem.</b>			23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore -- Maryland</b>		
24. FUNERAL DIRECTOR NAME <b>Lilly &amp; Zeiler Inc.</b> ADDRESS <b>1901 Eastern Ave./21231</b>						25a. DATE REC'D. BY REGISTRAR <b>DEC 18 1979</b>		25b. REGISTRAR'S SIGNATURE <b>Patricia McCreedy</b>			

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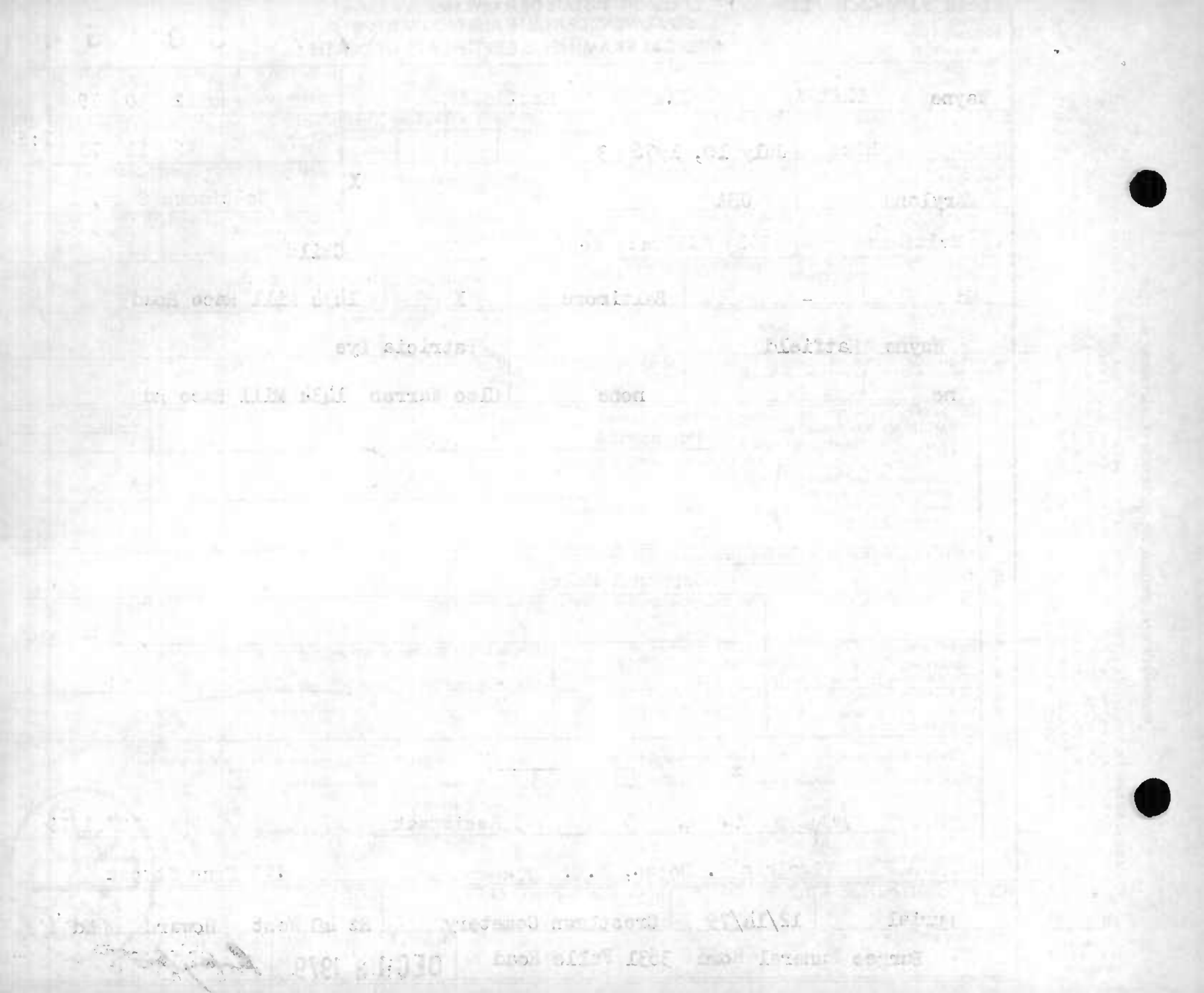
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

30154

1. DECEASED NAME (TYPE OR PRINT) <b>Wayne Phillip</b>		FIRST		MIDDLE		LAST		2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> 12 10 1979		2b. HOUR M	
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>July 10, 1976</b>		6. AGE (IN YEARS) LAST BIRTHDAY <b>3</b> YRS.		IF UNDER 1 YR. MONTHS DAYS HOURS MIN		2c. DATE PRONOUNCED DEAD MONTH DAY YEAR <b>12 11 1979</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City,</b> MD.					
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>1434 Millrace Road</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Child</b>		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE <b>Md</b>		13b. COUNTY <b>-</b>		13c. CITY OR TOWN <b>Baltimore</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>1434 Mill Race Road</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>Wayne Hatfield</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Patricia Dye</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>no</b>				16b. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT ADDRESS <b>Cleo Warren 1434 Mill Race Rd</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: <b>486- Pneumonia</b> IMMEDIATE CAUSE (a) } DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. } (b) } DUE TO, OR AS A CONSEQUENCE OF (c) }										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a). <b>Cerebral Palsy</b>											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE <i>Virginia L. Dolan</i>				TITLE (SPECIFY) <b>Assistant</b>				DATE SIGNED <b>12/11/79</b>			
EXAMINER'S NAME (TYPE OR PRINT) <b>Virginia L. Dolan, M.D.</b>				ADDRESS <b>111 Penn Street</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>				23b. DATE <b>12/14/79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>CrestLawn Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Rt 40 West Howard Md</b>			
24. FUNERAL DIRECTOR NAME <b>Burgee Funeral Home</b>						ADDRESS <b>3631 Falls Road</b>		25a. DATE REC'D. BY REGISTRAR <b>DEC 13 1979</b>		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>	

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING," IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PMA 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 30155	
1. DECEASED NAME (TYPE OR PRINT) <b>LEE</b> <b>HAWKINS</b>						2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH <b>12</b> DAY <b>2</b> YEAR <b>1979</b>		2b. HOUR <b>4:45</b> AM			
3. SEX <b>male</b>	4. RACE <b>black</b>	5. DATE OF BIRTH MONTH <b>11</b> DAY <b>19</b> YEAR <b>1936</b>	6. AGE (IN YEARS) (LAST BIRTHDAY) <b>43</b> YRS.	IF UNDER 1 YR. MONTHS DAYS HOURS MIN.	IF UNDER 24 HRS.	2c. DATE PRONOUNCED DEAD MONTH <b>12</b> DAY <b>2</b> YEAR <b>1979</b>		4. HOUR <b>4:45</b> AM			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>North Carolina</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.					
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Lutheran Hospital</b>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Laborer</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Beth-Steel</b>				
13a. STATE <b>Maryland</b>		13b. COUNTY		13c. CITY OR TOWN <b>Baltimore</b>		13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		13e. STREET ADDRESS <b>2755 W. North Ave.</b>			
14. FATHER'S NAME FIRST <b>John</b> MIDDLE LAST <b>Hawkins</b>				15. MOTHER'S MAIDEN NAME FIRST <b>Nannie</b> MIDDLE LAST <b>Cook</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>213-07-6059</b>		17. INFORMANT <b>Mrs. Angela Givens</b>		ADDRESS <b>Waynesboro, Ga. 516 Bryan St.</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Gunshot wound to chest and abdomen</b> DUE TO, OR AS A CONSEQUENCE OF (unspecified) Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR <b>7:24</b> P.M. MONTH <b>12</b> DAY <b>1</b> YEAR <b>79</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) <b>subject shot by assailant(s)</b>							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <b>porch</b>		21f. LOCATION STREET <b>1817 Poplar Grove</b> CITY OR TOWN <b>Baltimore</b> COUNTY <b>Maryland</b> STATE							
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE <b>Margareta A. Korell</b>		TITLE (SPECIFY) <b>Assistant</b> M.D.				MEDICAL EXAMINER		DATE SIGNED <b>12/2/79</b>			
EXAMINER'S NAME (TYPE OR PRINT) <b>Margarita A. Korell, M.D.</b>		ADDRESS <b>111 Penn Street</b>									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>12-7-79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Auburn Cemetery</b>		23d. LOCATION CITY OR TOWN <b>Baltimore City</b> COUNTY <b>Maryland</b> STATE					
24. FUNERAL DIRECTOR <b>Herbert E. Nutter</b>				ADDRESS <b>3035 W. North Ave.</b>		25a. DATE REC'D. BY REGISTRAR <b>DEC 4 1979</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>			

10. The following information is for your information only:

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

7 9 3 0 1 5 6  
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>Williams</b>		FIRST MIDDLE LAST <b>Hawkins</b>		2a. DATE OF DEATH MONTH DAY YEAR <b>12 5 79</b>		2b. HOUR <b>11 18 PM</b>	
3. SEX <b>MALE</b>		4. RACE <b>BLACK</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>7-4-1896</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>83</b> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>N.J.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>CITY</b> MD.	
10. CITY OR TOWN OF DEATH <b>BALTO</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>BON-SECURE</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>—</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>—</b>	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>MD.</b>		13b. COUNTY <b>BALTO</b>		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13d. STREET ADDRESS <b>501 Dolphin St. APT 915</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>William - Hawkins</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Sophia Young</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>YES</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>WW II 213-14-2271</b>		17. INFORMANT ADDRESS <b>Drucilla Johns - (Same)</b>			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) **Carcinoma of the prostate**  
**185-**  
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:  
(b) **Urinary tract Infection**  
DUE TO, OR AS A CONSEQUENCE OF  
(c) **DUE TO, OR AS A CONSEQUENCE OF**

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a):

MEDICAL CERTIFICATION

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>Nov 30</b> , 19 <b>77</b> , to <b>Dec 5</b> , 19 <b>79</b> , that (I) (we) last saw the deceased alive on <b>Dec 5</b> , 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>James K. Kahanawain</b>		DEGREE <b>MD</b> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c. DATE SIGNED <b>12-5-79</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>MCGES GEBBEMARLAM</b>		22e. ADDRESS					

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>12-10-1979</b>		23c. NAME OF CEMETERY OR CREMATORY <b>ARbutus mem.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>BALTO MD</b>	
24. FUNERAL DIRECTOR NAME <b>V. K. BAILEY</b>				ADDRESS <b>1348 N. CALHOUN ST.</b>		25a. DATE REC'D. BY REGISTRAR <b>DEC 7 1979</b>	
				25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>			



MD



*[Faint, illegible text and markings are visible across the page, likely bleed-through from the reverse side.]*

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

79 30157

REG. NO.

1. FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>WILLIAM J. HAWKINS</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>12 26 79</b>			2b. HOUR <b>9:23A</b>			
3. SEX <b>MALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>7 29 02</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>77</b> YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY</b> MD			
10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>VA MEDICAL CENTER BALTO.MD.</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Printer</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>MD. Drydock</b>	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE <b>MARYLAND</b>		13b. COUNTY <b>—</b>		13c. CITY OR TOWN <b>BALTIMORE</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>3450 6th Street 21225</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>John ——— Hawkins</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Ida ——— Mullen</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>YES</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>WW II</b>		17. INFORMANT ADDRESS <b>Miss Virginia Hawkins 3450 6th Street</b>					
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>PULMONARY EDEMA</b> <b>410-</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>PREVIOUS ANTEROLATERAL MYOCARDIAL INFARCT</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>6 DAYS</b> <b>6-79</b>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>RENAL INSUFFICIENCY</b>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>DEC. 18,</b> 19 <b>79</b> , to <b>DEC. 26,</b> 19 <b>79</b> , that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on <b>DEC. 26,</b> 19 <b>79</b> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>Randolph G. Whipp</b>				DEGREE <b>MD</b> ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c. DATE SIGNED <b>12/26/79</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>RANDOLPH G. WHIPPS</b>				22e. ADDRESS <b>3900 LOCH RAVEN BLVD, BALTO.MD. 21218</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>12-29-79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Louisa Park Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore Maryland</b>			
24. FUNERAL DIRECTOR NAME <b>Charles L. Stevens Funeral Home, Inc.</b>				ADDRESS <b>1501 E. FORT AVE</b>		25a. DATE REC'D. BY REGISTRAR <b>DEC 27 1979</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>	

MEDICAL CERTIFICATION

29

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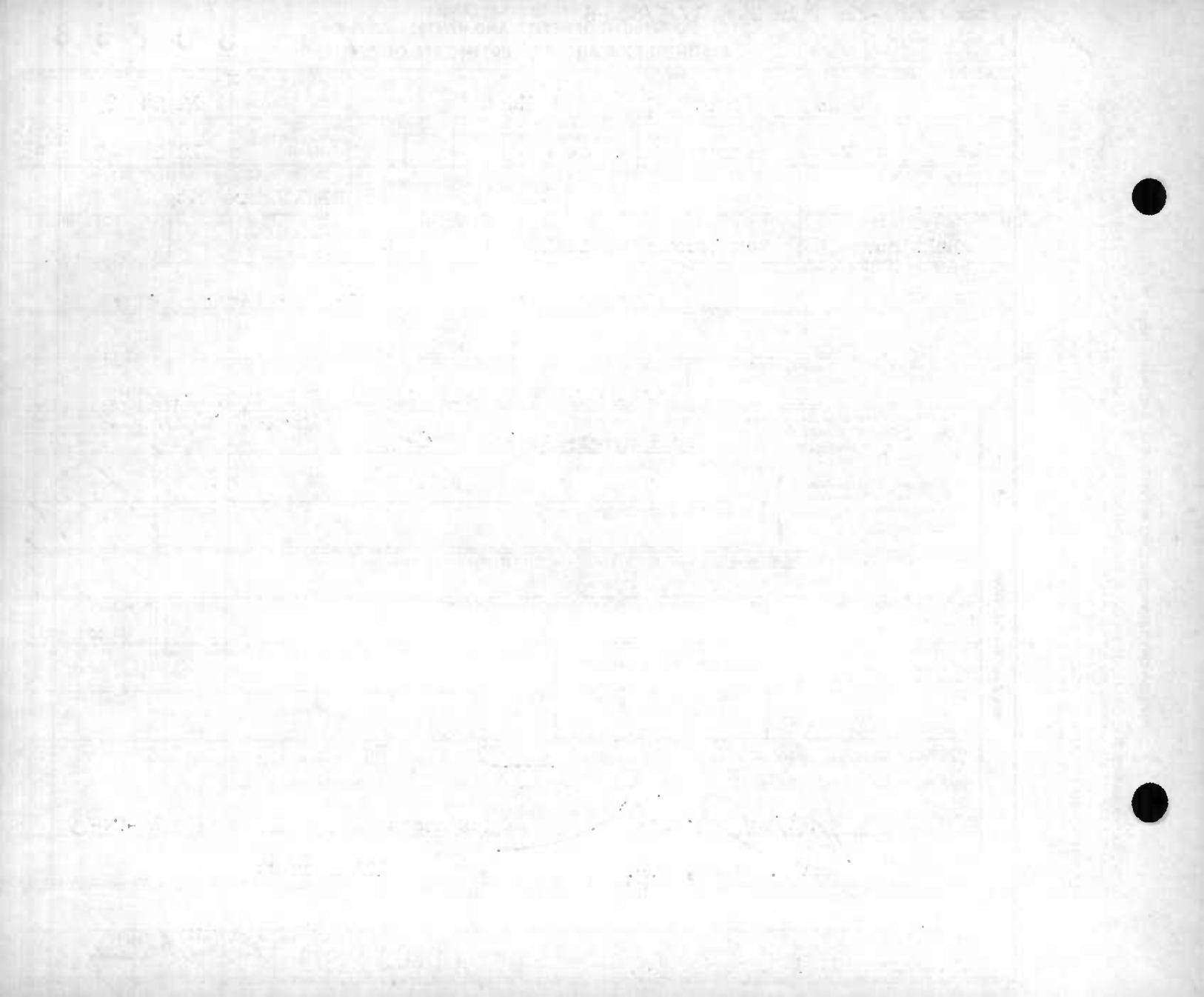
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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 3 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

Items #10a-22a Film G539 1/25/80 DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 30158					
1. DECEASED NAME (TYPE OR PRINT)			FIRST GENE MIDDLE ARCHIE LAST HAYES			2a. DATE KNOWN OF DEATH			<input checked="" type="checkbox"/> ESTIMATED MONTH 12 DAY 24 YEAR 1979		2b. HOUR M 10				
3. SEX male		4. RACE negro		5. DATE OF BIRTH MONTH 6 DAY 9 YEAR 41		6. AGE (IN YEARS) LAST BIRTHDAY 38 YRS.		IF UNDER 1 YR. MONTHS DAYS HOURS MIN		2c. DATE PRONOUNCED DEAD MONTH 12 DAY 24 YEAR 1979		2d. HOUR a 10			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) S.C.				7b. CITIZEN OF WHAT COUNTRY? USA				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.			
10. CITY OR TOWN OF DEATH Baltimore				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Bon Secour Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Laborer				12b. KIND OF BUSINESS OR INDUSTRY Construction			
13a. STATE Maryland				13b. COUNTY Baltimore				13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>				13e. STREET ADDRESS 2336 W. Lexington Street			
14. FATHER'S NAME FIRST MIDDLE LAST James M. Hayes						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Janie Mabry									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)				16b. SOCIAL SECURITY NO. 248-66-3442				17. INFORMANT Mamie Little				ADDRESS 1192 Preachtree St.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Focal myocarditis</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Winston, Salem, NC			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).															
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>															
ACTUAL SIGNATURE <i>Ann M. Dixon</i>						TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER						DATE SIGNED 12-24-79			
EXAMINER'S NAME (TYPE OR PRINT) Ann M. Dixon, M.D.						ADDRESS 111 Penn St									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 1-2-80				23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION CITY OR TOWN COUNTY STATE Kingstree S.C.			
24. FUNERAL DIRECTOR NAME W.C. March						ADDRESS 1101 E. North Ave.						25a. DATE REC'D. BY REGISTRAR DEC 31 1979		REGISTRAR'S SIGNATURE <i>John M. Brady</i>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH7 9 3 0 1 5 9  
REG. NO.1. FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>Lloyd Haynes</b>		2a. DATE OF DEATH MONTH DAY YEAR <b>December 27, 1979</b>		2b. HOUR <b>2:45p</b> M	
3. SEX <b>MALE</b>	4. RACE <b>BLACK</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>1 17 17</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>62</b> YRS	7. UNDER 1 YEAR MONTHS DAYS <b>0 0</b>
8a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>	8b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	9. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore, City</b> MD.	
10. CITY OR TOWN OF DEATH <b>Baltimore</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Maryland General Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY

13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Maryland</b>		13b. COUNTY <b>Baltimore</b>	13c. CITY OR TOWN <b>Baltimore</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS <b>3700 Gwynsfalls Parkway</b>
14. FATHER'S NAME FIRST MIDDLE LAST <b>OSCAR HAYNES</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>MARY V. DICKERSON</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b>	16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>214-18-3576</b>	17. INFORMANT ADDRESS <b>CARRIE WILLIAMS 4626 Manordene Rd.</b>			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c): PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Left Cerebral infarct, extensive</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
410- Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost DUE TO, OR AS A CONSEQUENCE OF (b) <b>Myocardial Hypertrophy</b> DUE TO, OR AS A CONSEQUENCE OF (c)		

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>Resolving left ventricular myocardial infarct</b>			
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (this hospital) attended the deceased from <b>December 25, 1979</b> to <b>December 27, 1979</b> , that (I) (we) lost saw the deceased alive on above (I) (we) did (I) (we) view the body after death.			
22b. SIGNATURE <b>Harry E. Nervino, M.D.</b>		DEGREE <b>M.D.</b>	22c. DATE SIGNED <b>12/28/79</b>
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Harry Nervino, M.D.</b>		22e. ADDRESS <b>c/o Maryland General Hospital</b>	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>	23b. DATE <b>12-31-79</b>	23c. NAME OF CEMETERY OR CREMATORY <b>KING MEM. PARK</b>	23d. LOCATION CITY OR TOWN COUNTY STATE <b>BALTIMORE CO., MD.</b>
24. FUNERAL DIRECTOR NAME <b>Wm. C. March F/H</b>		ADDRESS <b>1101 E. North Ave.</b>	25a. DATE REC'D. BY REGISTRAR <b>DEC 31 1979</b>
		25b. REGISTRAR'S SIGNATURE <b>Barney McCurdy</b>	

1452

December 27, 1979

Warner

Cloud

Baltimore, City

Harland General Hospital

Baltimore

Baltimore

Baltimore

WAVE

CEAR

Left Cervical infarct, extensive

Neocortical hyperactivity

Neocortical left ventricular neocortical infarct

X

December 27, 1979

December 27, 1979

XXX

Harland General Hospital

Harland General Hospital

12-21-79

12-21-79

Harland General Hospital



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# STATE OF MARYLAND

## DEPARTMENT OF HEALTH AND MENTAL HYGIENE

### CERTIFICATE OF DEATH

30160

1. DECEASED-NAME (Type or print) <b>Baby Girl</b>		First Middle Lost		2a. DATE OF DEATH Month <b>12</b> Day <b>2</b> Year <b>79</b>		2b. HOUR <b>4:55 AM</b>	
3. SEX <b>Female</b>		4. RACE <b>Black</b>		5. DATE OF BIRTH <b>11-26-79</b>		6. AGE (In years lost birthday) YRS. MONTHS DAYS	
7a. BIRTHPLACE (State or foreign country) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>BALTIMORE CITY</b> Md.	
10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>University of Md. Hospital</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>md.</b>		13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>City</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET AND NUMBER <b>2627 Puget St.</b>		14. FATHER'S NAME First Middle Lost		15. MOTHER'S MAIDEN NAME First Middle Lost <b>Vernell Hazelton</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b. SOCIAL SECURITY NO. <b>-</b>		17. INFORMANT <b>-</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac Arrest</b> <b>7469</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Congenital Cardiac Disease</b> DUE TO, OR AS A CONSEQUENCE OF (c)							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS CONTRIBUTING <input type="checkbox"/> UNDERLYING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) <del>(this hospital)</del> attended the deceased from <b>11-26</b> , 19 <b>79</b> , to <b>12-2</b> , 19 <b>79</b> , that (I) <del>(we)</del> last saw the deceased alive on <b>12-2</b> 19 <b>79</b> , and that in <del>(my)</del> (our) opinion death occurred on the date and hour and from the causes stated above, (I) <del>(we)</del> (did) (did not) view the body after death.							
22b. SIGNATURE <b>Saralyn S. Vogel MD</b>				DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>12-2-79</b>	
22d. PHYSICIAN'S NAME (Type) <b>SARALYN S. VOGEL MD</b>				22e. ADDRESS <b>Pediatrics - University of Md. Hosp.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		23b. DATE <b>12/6/79</b>		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)	
24. FUNERAL DIRECTOR <b>Anatomy Board</b>		ADDRESS <b>Balto., Md.</b>		25a. REC'D BY REGISTRAR DATE <b>DEC 7 1979</b>		25b. REGISTRAR'S SIGNATURE <b>Anthony McCreedy</b>	

MEDICAL CERTIFICATION

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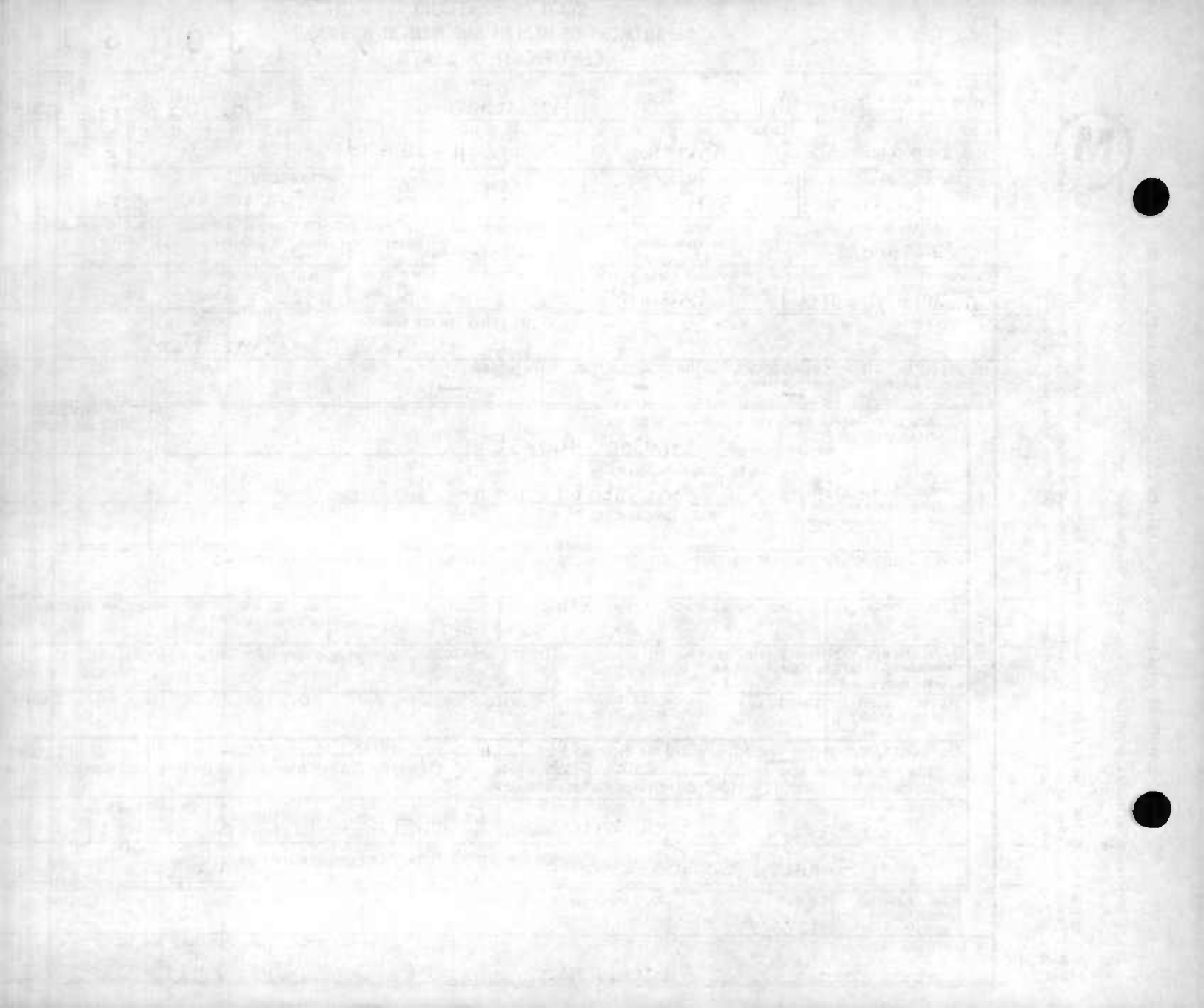
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										
1. FOR STATE REGISTRAR		7 9 3 0 1 6 1								
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR
Beulah H. Headley								12-3-79		11:45 PM
3 SEX	4 RACE	5 DATE OF BIRTH MONTH DAY YEAR		6 AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		
Female	White	10 31 01		78						
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH						
Virginia	U S A			BALTIMORE CITY MD.						
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY			
BALTIMORE	ST AGNES HOSPITAL			Housewife						
13a. STATE		13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS					
Maryland		Baltimore	Catonsville		105 Fairfield Drive					
14 FATHER'S NAME FIRST MIDDLE LAST		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST								
Lloyd M. Hundley		Mary Fisher								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS						
no		212-05-6536		Chester L. Headley, 105 Fairfield Dr.						
18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardio Resp. Arrest</u> <u>410-</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Myocardial Infarction</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>AASHD = aortic stenosis</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
		P.M. 19								
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
				Now 22 19 79		Dec 3 19 79				
22a. I certify that (I) (this hospital) attended the deceased from <u>Dec 3</u> 19 <u>79</u> , to <u>Dec 3</u> 19 <u>79</u> , that (I) (we) lost saw the deceased alive on <u>Dec 3</u> 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE		22c. DATE SIGNED								
<u>E. Myers M.D.</u>		12-3-79								
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS								
E. MYERS M.D.		900 CATON AVE. BALTIMORE, MD. 21229								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE	23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE					
Entombment		12/6/79	Lorraine Mausoleum		Baltimore, Maryland					
24. FUNERAL DIRECTOR NAME		1630 Edmondson Ave., Catonsville, MD.		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE				
Witzke Funeral Home of Catonsville, P.A. 21228				DEC 7 1979		<u>Fitzgerald</u>				

BALTIMORE CITY

BALTIMORE CITY HOSPITAL



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DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

79 30162

1. FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>Margaret</b>			2a. DATE OF DEATH MONTH <b>11</b> DAY <b>29</b> YEAR <b>79</b>			2b. HOUR <b>9:24</b> A.M.				
3 SEX <b>FEMALE</b>		4 RACE <b>BLACK</b>		5. DATE OF BIRTH MONTH <b>JULY</b> DAY <b>14</b> YEAR <b>1934</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>44 YEARS</b>		IF UNDER 1 YEAR MONTHS <b>4</b> DAYS <b>14</b> HOURS <b>34</b> MIN		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>BALTIMORE, MARYLAND</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY,</b> MD.				
10 CITY OR TOWN OF DEATH <b>Balto.</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>PROVIDENT HOSPITAL</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>POSTAL CLERK</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>U.S. POST OFF.</b>		
13a. STATE <b>BALTO.</b>			13b. COUNTY		13c. CITY OR TOWN <b>BALTIMORE</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>6802 WILDWOOD AVENUE</b>	
14 FATHER'S NAME FIRST <b>REMUS</b> MIDDLE <b>J.</b> LAST <b>GIBSON</b>			15 MOTHER'S MAIDEN NAME FIRST <b>MARGARET</b> MIDDLE <b>GIBSON</b> LAST <b>GIBSON</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>			16b. SOCIAL SECURITY NO. <b>216-32-9162</b>		17 INFORMANT ADDRESS <b>MR. ANDY L. HEGGINS 6802 WILDWOOD AVE.</b>					
18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardio-Pulmonary arrest</b> <b>1749</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>Hepatic and renal failure</b> (c) <b>Melanotic Carcinoma of Breast</b> DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): <b>None</b>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>11/26, 1979</b> to <b>11/29, 1979</b> , that (I) (we) last saw the deceased alive on <b>11/29, 1979</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <b>Ronald D. Miles, M.D.</b>			DEGREE			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>11/29/79</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Ronald D. Miles, M.D.</b>			22e. ADDRESS <b>Provident Hospital</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>			23b. DATE <b>12-4-79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>ARBUTUS MEM. PARK</b>		23d. LOCATION CITY OR TOWN <b>BALTIMORE, MD.</b> COUNTY STATE			
24. FUNERAL DIRECTOR NAME <b>LEROY O. DYETT &amp; SON, INC.</b> ADDRESS <b>4600 LIBERTY HGHTS AVE.</b>					25a. DATE REC'D. BY REGISTRAR <b>DEC 3 1979</b>		25b. REGISTRAR'S SIGNATURE <b>Ruby Roberts</b>			

MEDICAL CERTIFICATION



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STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

79 30163

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <i>Betty Lee Helm</i>			2a. DATE OF DEATH MONTH <i>12</i> DAY <i>6</i> YEAR <i>79</i>		2b. HOUR <i>4:35 PM</i> M
3 SEX <i>FEMALE</i>	4 RACE <i>WHITE</i>	5. DATE OF BIRTH MONTH <i>4</i> DAY <i>18</i> YEAR <i>33</i>		6 AGE (IN YEARS LAST BIRTHDAY) <i>46</i> YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Maryland</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	
9. CITY OR TOWN OF DEATH <i>Baltimore-city</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Univ of Maryland Hosp (BCRP)</i>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>secretary</i>	
10. CITY OR TOWN OF DEATH <i>Baltimore-city</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Univ of Maryland Hosp (BCRP)</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>secretary</i>	
13a. STATE <i>3322B Maryland</i>			13b. COUNTY <i>-</i>	13c. CITY OR TOWN <i>Baltimore</i>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST <i>Mitchell</i> MIDDLE <i>-</i> LAST <i>Edson</i>		15. MOTHER'S MAIDEN NAME FIRST <i>Helen</i> MIDDLE <i>-</i> LAST <i>Hofmann</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>no</i>		16b. SOCIAL SECURITY NO. <i>215-28-7799</i>		17. INFORMANT <i>Pt Chant</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>septicemia</i> <i>2080</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>leukocytopenia</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>acute leukemia</i>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):					
19a. DATE OF OPERATION <i>9/19/79</i>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>Good (death is not related to surgery)</i>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <i>OCT 19 79</i> , to <i>DEC 19 79</i> , that (I) (we) last saw the deceased alive on <i>12/6/79</i> , 19 <i>79</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.					
22b. SIGNATURE <i>Ayman Al-Hakim</i>		DEGREE <i>M.D.</i>		22c. DATE SIGNED <i>12/6/79</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Ayman Al-Hakim</i>		22e. ADDRESS <i>22 Green St Balt - 21201</i>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>BURIAL</i>		23b. DATE <i>12/18/79</i>		23c. NAME OF CEMETERY OR CREMATORY <i>LONDON PARK</i>	
23d. LOCATION CITY OR TOWN <i>BALTO. MD</i>		COUNTY <i>-</i>		STATE <i>-</i>	
24. FUNERAL DIRECTOR NAME <i>Paul E. Howard</i>		ADDRESS <i>3617 Chant Ave</i>		25a. DATE REC'D. BY REGISTRAR <i>DEC 11 1979</i>	
25b. REGISTRAR'S SIGNATURE <i>Henry M. Brady</i>					

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Burial may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



DRIVE IT STRAIGHT

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10/11/10



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										7 9 3 0 1 6 4			
1. FOR STATE REGISTRAR		REG. NO.											
1. DECEASED NAME (TYPE OR PRINT)		FIRST MAST		MIDDLE NMN		LAST HENDRIX		2a. DATE OF DEATH		MONTH 12	DAY 10	YEAR 79	2b. HOUR 11:00PM
3. SEX MALE		4. RACE BLACK		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) LEESVILLE, S.C.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE, CITY							
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) VAMC, LOCH RAVEN		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY							
13a. STATE MARYLAND		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 1116 Argyle Ave.					
14. FATHER'S NAME		FIRST Calvin		MIDDLE Hendrix		LAST Hendrix		15. MOTHER'S MAIDEN NAME		FIRST Estelle		MIDDLE Hendrix	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WWII		17. INFORMANT Laura Hendrix		ADDRESS 1116 Argyle Ave.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>probable acute MI.</u> 410- DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a). ASCVD / AODM.													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE 3900 LOCH RAVEN BLVD., BALTO. MD. 21218									
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>11-28</u> , 19 <u>79</u> , to <u>10-10</u> , 19 <u>79</u> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>12-10</u> , 19 <u>79</u> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above <input checked="" type="checkbox"/> (we) (did) <input checked="" type="checkbox"/> (not) view the body after death.													
22b. SIGNATURE <u>Paul A. Chavis, MD</u>		DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c. DATE SIGNED 12/11/79.					
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12/15/79		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Anne Arundel Co., Md.							
24. FUNERAL DIRECTOR NAME Wm C March F/H		ADDRESS 1101 E. North Ave.		25a. DATE REC'D. BY REGISTRAR DEC 13 1979		25b. REGISTRAR'S SIGNATURE <u>Barry McCreedy</u>							

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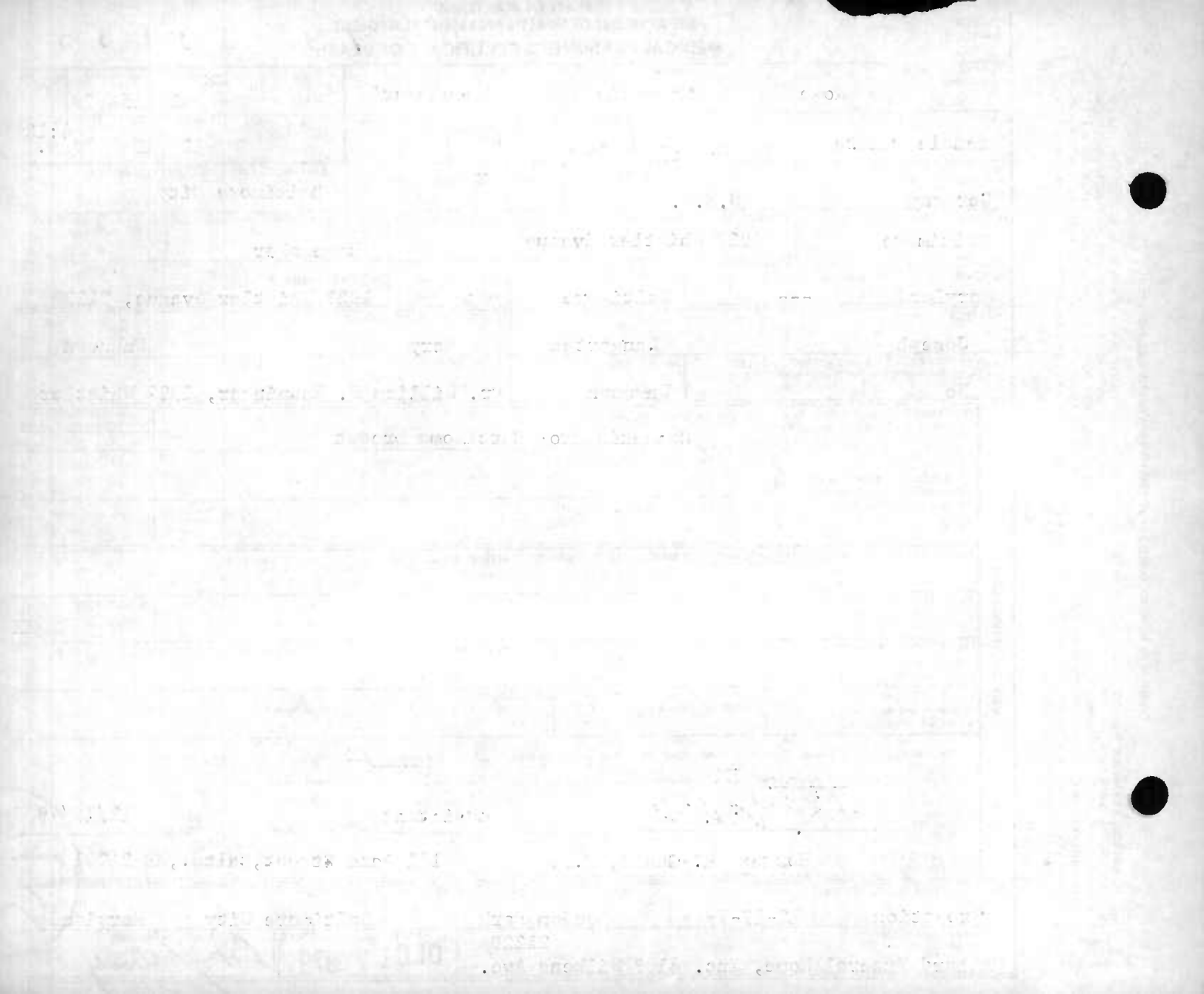
TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PA 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 30165

1- FOR STATE REGISTRAR		20. DATE KNOWN OF DEATH		21. MONTH		22. DAY		23. YEAR		24. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		20. DATE KNOWN OF DEATH		21. MONTH	
Rose		Mary		Henninger				12		15	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS)		7. IF UNDER 1 YR.		8. IF UNDER 24 HRS.	
female		white		08 08 91		88 YRS.		MONTHS		DAYS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED		9. NEVER MARRIED		10. WIDOWED		11. DIVORCED	
Germany		U.S.A.		X							
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY					
Baltimore		1927 Whistler Avenue		Homemaker							
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS			
Maryland		---		Baltimore		YES X NO		1927 Whistler Avenue, 21230			
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16. WAS DECEASED EVER IN U.S. ARMED FORCES?		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS	
Joseph		Mary		No		Unknown		Dr. William F. Henninger, 1927 Whistler			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)	
PART I DEATH WAS CAUSED BY:		PART I DEATH WAS CAUSED BY:		PART I DEATH WAS CAUSED BY:		PART I DEATH WAS CAUSED BY:		PART I DEATH WAS CAUSED BY:		PART I DEATH WAS CAUSED BY:	
IMMEDIATE CAUSE (a)		IMMEDIATE CAUSE (a)		IMMEDIATE CAUSE (a)		IMMEDIATE CAUSE (a)		IMMEDIATE CAUSE (a)		IMMEDIATE CAUSE (a)	
Cachexia from Carcinoma breast		Cachexia from Carcinoma breast		Cachexia from Carcinoma breast		Cachexia from Carcinoma breast		Cachexia from Carcinoma breast		Cachexia from Carcinoma breast	
DUE TO, OR AS A CONSEQUENCE OF		DUE TO, OR AS A CONSEQUENCE OF		DUE TO, OR AS A CONSEQUENCE OF		DUE TO, OR AS A CONSEQUENCE OF		DUE TO, OR AS A CONSEQUENCE OF		DUE TO, OR AS A CONSEQUENCE OF	
(b)		(b)		(b)		(b)		(b)		(b)	
DUE TO, OR AS A CONSEQUENCE OF		DUE TO, OR AS A CONSEQUENCE OF		DUE TO, OR AS A CONSEQUENCE OF		DUE TO, OR AS A CONSEQUENCE OF		DUE TO, OR AS A CONSEQUENCE OF		DUE TO, OR AS A CONSEQUENCE OF	
(c)		(c)		(c)		(c)		(c)		(c)	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).		PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).		PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).		PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).		PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).		PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		19c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)		20. AUTOPSY?		21. YES		22. NO	
						YES X NO					
21a. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)		21d. INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION CITY OR TOWN COUNTY STATE	
		P.M. 19									
22a. I certify that I took charge of the remains described above, held on death resulted from:		22a. I certify that I took charge of the remains described above, held on death resulted from:		22a. I certify that I took charge of the remains described above, held on death resulted from:		22a. I certify that I took charge of the remains described above, held on death resulted from:		22a. I certify that I took charge of the remains described above, held on death resulted from:		22a. I certify that I took charge of the remains described above, held on death resulted from:	
Natural causes X Accident Suicide Homicide Undetermined manner		Natural causes X Accident Suicide Homicide Undetermined manner		Natural causes X Accident Suicide Homicide Undetermined manner		Natural causes X Accident Suicide Homicide Undetermined manner		Natural causes X Accident Suicide Homicide Undetermined manner		Natural causes X Accident Suicide Homicide Undetermined manner	
ACTUAL SIGNATURE		TITLE (SPECIFY)		DATE		12/16/79		12/16/79		12/16/79	
Hormez R. Guard, M.D.		Assistant		MEDICAL EXAMINER		SIGNED		SIGNED		SIGNED	
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS		111 Penn Street, Balto., MD 21201		111 Penn Street, Balto., MD 21201		111 Penn Street, Balto., MD 21201		111 Penn Street, Balto., MD 21201	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE		23d. LOCATION CITY OR TOWN COUNTY STATE		23d. LOCATION CITY OR TOWN COUNTY STATE	
Cremation		12-17-79		Loudon Park		Baltimore City Maryland		Baltimore City Maryland		Baltimore City Maryland	
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Hubbard Funeral Home, Inc.		4107 Wilkens Ave.		21229		DEC 17 1979		DEC 17 1979		DEC 17 1979	





FOR  
1 - STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

7 9 3 0 1 6 6

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>EDITH</b>		FIRST MIDDLE LAST <b>HENRY</b>		2a. DATE OF DEATH MONTH DAY YEAR <b>12-19-79</b>		2b. HOUR <b>9:19A</b> M	
3. SEX <b>Female</b>		4. RACE <b>Negro</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>4 1, 1920</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>59</b> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>South Carolina</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY</b> MD	
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>THE JOHNS HOPKINS HOSPITAL</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Maryland</b>		13b. COUNTY <b>Baltimore</b>		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13d. STREET ADDRESS <b>2812 Fox Street</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Sylvester Perkins</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Clara Washington</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO <b>251-58-2253</b>		17. INFORMANT ADDRESS <b>Leslie Wright 98 McClain Avenue</b>			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Respiratory Arrest</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
1949 DUE TO, OR AS A CONSEQUENCE OF (b) <b>hypercalcemia</b>		6 mos	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <b>Metastatic Breast Cancer</b>		3 years	

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22. I certify that (1) (this hospital) attended the deceased from <b>12/14</b> , 19 <b>79</b> , to <b>12/19</b> , 19 <b>79</b> , that (1) (we) last saw the deceased alive on <b>12/19</b> , 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) did (did not) view the body after death.							
22b. SIGNATURE <b>P. S. Upton</b>		DEGREE <b>HOLP</b>		22c. DATE SIGNED <b>12/19/79</b>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>P. S. Upton</b>		22e. ADDRESS <b>JOHNS HOPKINS HOSPITAL</b>					

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>12/24/79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Mount Calvary Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore, Maryland</b>	
24. FUNERAL DIRECTOR NAME ADDRESS <b>Wm. C. March F/H 1101 East North Avenue</b>				25a. DATE REC'D. BY REGISTRAR <b>DEC 20 1979</b>		25b. REGISTRAR'S SIGNATURE <b>Anthony McCreedy</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that a death certificate be executed within 24 hours after death. Page 4 of this certificate is to be retained by the hospital or attending physician. The law requires that a death certificate be executed within 24 hours after death. Page 4 of this certificate is to be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial transit permit. Then please return the certificate to the State Department of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



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DEC 20 1973

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 IN YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 30167			
1. FOR STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT)								2a. DATE KNOWN OF DEATH		2b. HOUR	
		FIRST MIDDLE LAST <b>Robert Sherman Henry</b>								ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR <b>12 6 19 79</b>		M <b>1:40 P M</b>	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YR.		IF UNDER 24 HRS.		2c. DATE PRONOUNCED DEAD	
Male		White		MONTH DAY YEAR <b>04 28 21</b>		YRS. <b>58</b>		MONTHS DAYS HOURS MIN		MONTH DAY YEAR <b>12 7 19 79</b>			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)				7b. CITIZEN OF WHAT COUNTRY?				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH	
Virginia				U.S.A.								Baltimore City, MD.	
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY	
Baltimore				1518 W. Pratt Street				Laborer				Donut Corp.	
13a. STATE				13b. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS				of America	
Maryland				---		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		1518 W. Pratt Street					
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME									
FIRST MIDDLE LAST <b>Robert H. Henry</b>				FIRST MIDDLE LAST <b>Ella C. Henry</b>									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)				16b. SOCIAL SECURITY NO.		17. INFORMANT				ADDRESS			
Yes				WW II		219-05-7998				Katherine V. Ebaugh 1518 W. Pratt St.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic Cardiovascular Disease</b> 4292 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY?	
												YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .													
ACTUAL SIGNATURE <i>Virginia L. Dolan</i>				TITLE (SPECIFY) Assistant				DATE SIGNED 12/8/79					
EXAMINER'S NAME (TYPE OR PRINT) Virginia L. Dolan, M.D.				ADDRESS 111 Penn Street									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE		23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION CITY OR TOWN COUNTY STATE			
Burial				12-11-79		Good Shepherd				Ellicott City Howard Md.			
24. FUNERAL DIRECTOR NAME				25a. DATE REC'D. BY REGISTRAR				25b. REGISTRAR'S SIGNATURE					
Hubbard Funeral Home, Inc. 4107 Wilkens Ave.				21229				DEC 10 1979 <i>Rafael A. Brady</i>					



1890

978-0-13-035207-0

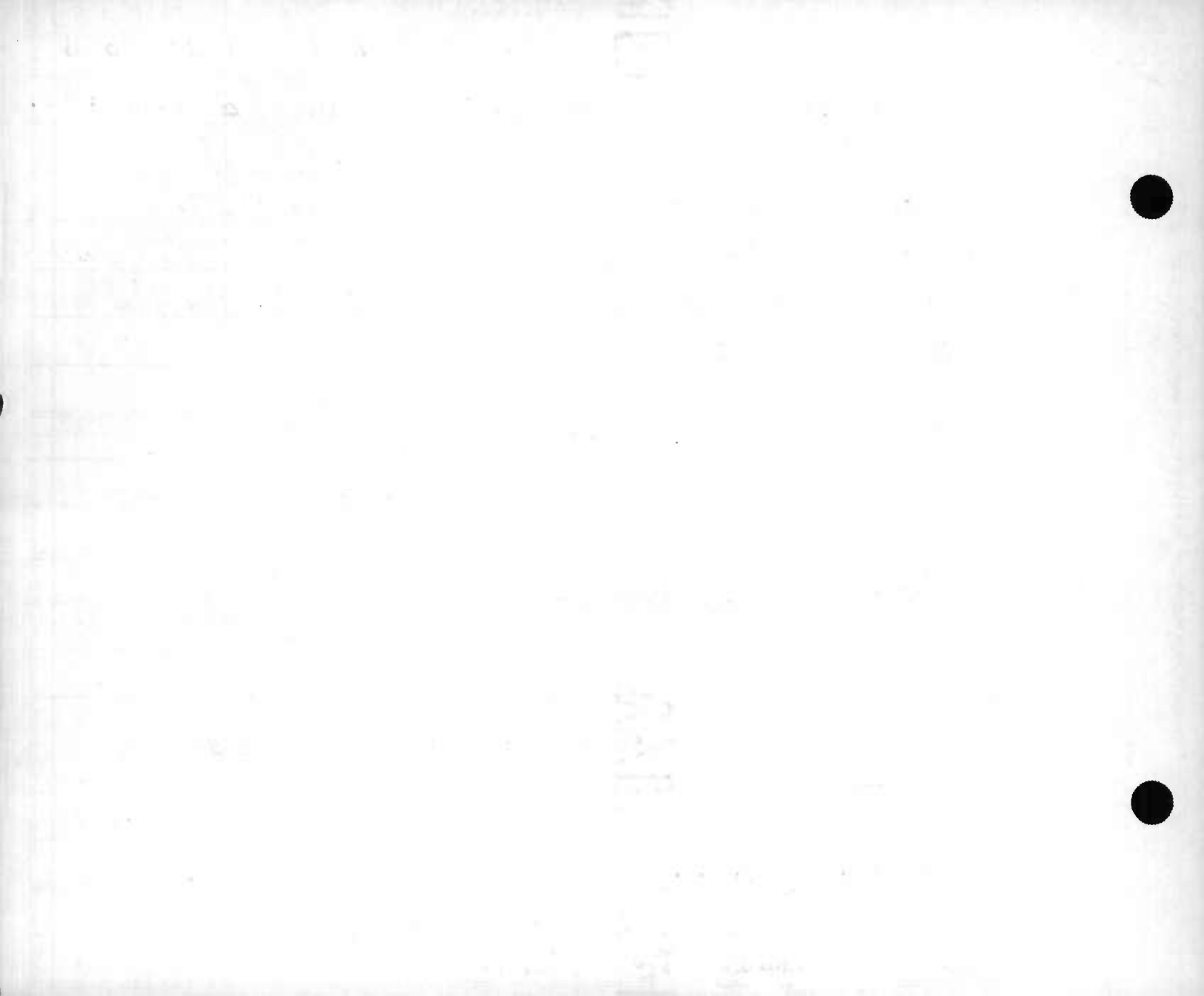


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

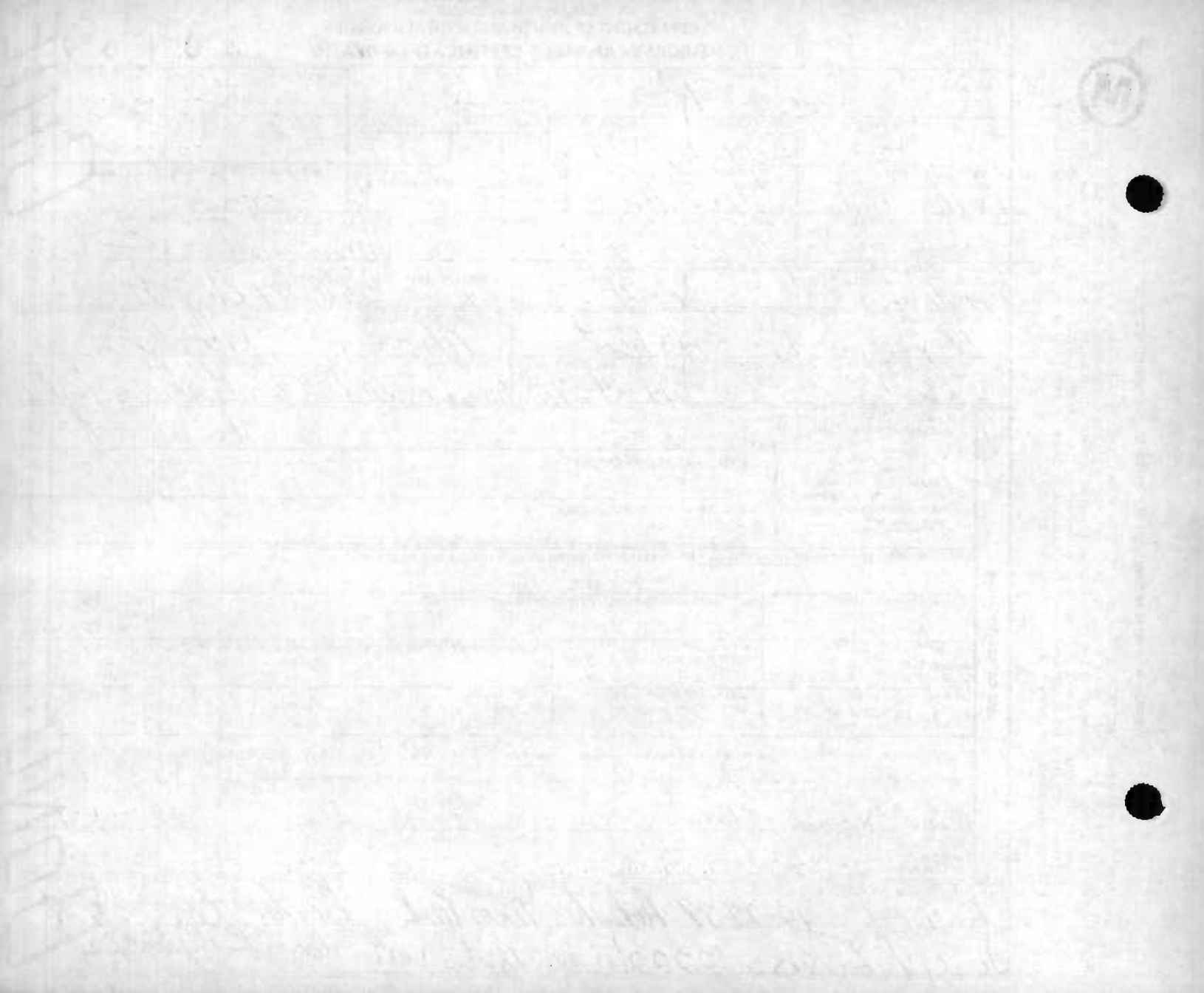
STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		7 9 3 0 1 6 8		REG. NO.					
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH MONTH DAY YEAR	
CARROLL		L		Herbert				Dec 6 1979	
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		7b. HOUR	
MALE		White		1 18 11		68		9:45 P. M.	
7c. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7d. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			
MD		U. S. A.				Baltimore City		MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
Baltimore		Bel Air Nursing Home		OWNER		Riding Stable			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13b. CITY OR TOWN		13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13d. STREET ADDRESS			
MD		Baltimore		HYDES		13022 Long Green Pike			
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT ADDRESS	
Nicholas Herbert		Margaret		No		218-15-2445		Family RECORDS	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarction</u>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
410- <u>410-</u> DUE TO, OR AS A CONSEQUENCE OF <u>Arteriosclerotic Cardiovascular Disease</u>								year	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF <u>Coronary Arteriosclerosis</u>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Carcinoma of the lung; Anemia; severe Chronic Obstructive Pulmonary Disease</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (the hospital) attended the deceased from <u>5/20/1979</u> to <u>12/10/1979</u> , that (I) (we) lost saw the deceased alive on <u>11/15/1979</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.									
22b. SIGNATURE <u>Albert B. Bradley</u>		DEGREE <u>MD</u>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>12/7/79</u>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS							
Albert B. Bradley, M.D.		4900 Belair Road Baltimore, Maryland		# 06					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE			
CREMATION		12-10-79		WESTVIEW MEM. PK.		Baltimore MD.			
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
EVANS Funeral Chapel		8800 Hanford Rd		DEC 11 1979		<u>Robert M. Bradley</u>			



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 30169

1. FOR STATE REGISTRAR		2a. DATE KNOWN OF DEATH		MONTH DAY YEAR		TIME HOUR	
1. DECEASED NAME (TYPE OR PRINT)		FIRST Henry		MIDDLE R		LAST Herbert	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS)	
Male		Black		Aug 12, 1922		57 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. DATE PRONOUNCED DEAD	
Baltimore, Md.		U.S.A.				12 21 1979	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Baltimore City		602 Pitcher Street		Unemployed			
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?	
Maryland		Baltimore				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16. SOCIAL SECURITY NO.		17. INFORMANT	
Henry R		Alice Riegeley		214-243710		Mrs. Laura McCreary	
18a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		18b. SOCIAL SECURITY NO.		18c. INFORMANT		18d. ADDRESS	
yes		214-243710		Mrs. Laura McCreary		2510 Oakley Ave	
19. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		20. IMMEDIATE CAUSE (a)		21. DUE TO, OR AS A CONSEQUENCE OF		22. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
486-		Pneumonia					
23. PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)		Emphysema					
24. DATE OF OPERATION		25. CONDITION FOR WHICH OPERATION WAS PERFORMED?		26. AUTOPSY?		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
27a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		27b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		27c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
27d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		27e. PLACE OF INJURY (AT HOME, STREET, FACILITY, FARM, ETC.)		27f. LOCATION STREET CITY OR TOWN COUNTY STATE			
28a. I certify that I took charge of the remains described above, held on		Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion		death resulted from:		Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>	
29. ACTUAL SIGNATURE		30. TITLE (SPECIFY)		31. DATE SIGNED		32. MEDICAL EXAMINER	
Virginia L. Dolan		M.D. Assistant		12/21/79			
33. EXAMINER'S NAME (TYPE OR PRINT)		34. ADDRESS		35. CITY OR TOWN		36. STATE	
Virginia L. Dolan, M.D.		111 Penn St.		Balto., MD.			
37a. BURIAL, CREMATION, REMOVAL (TYPE)		37b. DATE		37c. NAME OF CEMETERY OR CREMATORY		37d. LOCATION CITY OR TOWN COUNTY STATE	
Burial		12-27-79		Arbutus Memorial		Baltimore, Md.	
38. FUNERAL DIRECTOR NAME		39. ADDRESS		40. DATE REC'D. BY REGISTRAR		41. REGISTRAR'S SIGNATURE	
Joseph L. Russ		2222 W. North Ave.		JAN 7 1980		R. J. McCreary	



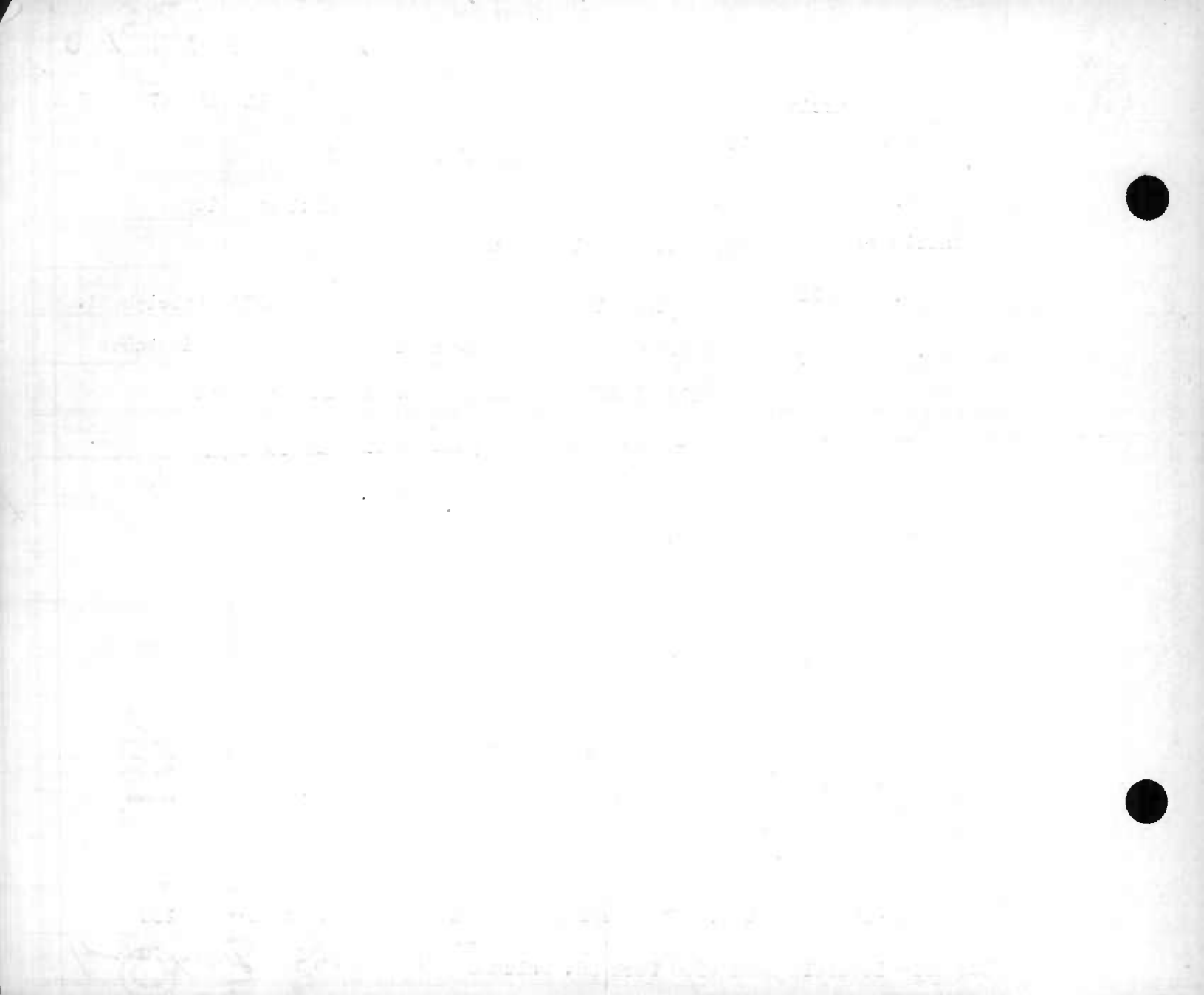
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
1. FOR STATE REGISTRAR		7 9 3 0 1 7 0 REG. NO.									
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR 5 A M	
Hattie		H.		Hermann				12 13 1979			
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 10 15 1886		6. AGE (IN YEARS LAST BIRTHDAY) 93 YRS		7. IF UNDER 1 YEAR MONTHS DAYS		8. IF UNDER 24 HRS HOURS MIN	
9a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pa.		9b. CITIZEN OF WHAT COUNTRY? USA		10. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.					
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Long Green Nursing Home						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE Md.		13b. COUNTY Balto		13c. CITY OR TOWN Lutherville		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 1324 Burleigh Rd.			
14. FATHER'S NAME FIRST MIDDLE LAST Wm. B Crawford				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Margaret Bierbauer							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 175 07 3728B		17. INFORMANT ADDRESS Evelyn L. Manella Same							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory Failure</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Generalized Atherosclerosis</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u></u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 72 Hrs 15 yrs	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22. I certify that (I) (this hospital) attended the deceased from <u>12 October 1979</u> to <u>13 Dec 1979</u> , that (I) <u>was</u> lost saw the deceased alive on <u>12/11/79</u> 19 <u>79</u> , and that in (my) <u>own</u> opinion death occurred on the date and hour and from the causes stated above, (I) <u>was</u> (did) (did not) view the body after death.											
22a. SIGNATURE <u>Charles F. O'Connor</u>		22b. PHYSICIAN'S NAME (TYPE OR PRINT)		22c. ADDRESS		22d. DATE SIGNED <u>12/13/79</u>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 12 14 1979		23c. NAME OF CEMETERY OR CREMATORY Westview Crematory		23d. LOCATION CITY OR TOWN COUNTY STATE Catonsville Balto Md					
24. FUNERAL DIRECTOR NAME ADDRESS Mitchell-Wiedefeld Home 6500 York Rd. Balto Md						25. DATE REC'D. BY REGISTRAR DEC 1 8 1979		26. REGISTRAR'S SIGNATURE <u>Ernest H. Brady</u>			



TO HOSPITAL, ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 7930171			
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR
WILLIAM		B.		HERNDON				12-18-79					3:30 P.M.
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS			
M		B		9 2 02		77 YRS		MONTHS		DAYS		HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH							
N.C.		USA				Balto. City						MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY							
Balto.		JOHN L. DEATON MEDICAL CENTER											
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS					
Md.				Balto.		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		1619 Clif+view Ave.					
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME											
John		F. Herndon		Gaither		Smith							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS							
No		217-03-7079		Rose H. Smith		1619 Clif+view Ave.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Pulmonary arrest</u> 911- Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Probable aspiration</u> (c) <u></u> DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Decubitus ulcers; renal insufficiency</u>													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?							
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
		November											
22a. I certify that (I) (this hospital) attended the deceased from <u>Sept. 20, 1979</u> to <u>December 18, 1979</u> , that (I) (we) lost saw the deceased alive on <u>Dec. 18, 1979</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (we) (did) (did not) view the body after death.													
22b. SIGNATURE		DEGREE		22c. DATE SIGNED									
Joanne E. Williams		M.D.		12-18-79									
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS											
Joanne E. Williams, M.D.													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE							
Burial		12/22/79		Baltimore Cem.		Baltimore, Md.							
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE							
Wm C March F/H		1101 E. North Ave.		DEC 26 1979		R. H. McCreedy							





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, please detach for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		7 9 3 0 1 7 2		REG. NO.					
1. DECEASED NAME (TYPE OR PRINT)		FIRST <u>Martha</u> MIDDLE <u>Marcella</u> LAST <u>Herzing</u> <u>MARTHA M HERZING</u>		2a. DATE OF DEATH MONTH DAY YEAR <u>December 20, 1979</u>		2b. HOUR <u>10 AM</u>			
3. SEX <u>Female</u>		4. RACE <u>Caucasian</u>		5. DATE OF BIRTH MONTH DAY YEAR <u>Sept. 8, 1890</u>		6. AGE (IN YEARS LAST BIRTHDAY) <u>89</u> YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>Maryland</u>		7b. CITIZEN OF WHAT COUNTRY? <u>USA</u>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <u>Baltimore City</u> MD.			
10. CITY OR TOWN OF DEATH <u>Baltimore</u>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>Bon Secours Hospital</u>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>Housewife</u>		12b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <u>Maryland</u>		13b. COUNTY <u>Baltimore</u>		13c. CITY OR TOWN <u>Baltimore</u>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <u>500 S. Beechfield Ave. 21229</u>	
14. FATHER'S NAME FIRST MIDDLE LAST <u>George Bentz</u>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <u>Unknown to Records</u>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <u>No</u>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <u>N/A</u>		17. INFORMANT ADDRESS <u>Mrs. Esther C. Wagner Same as # 13</u>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>MYOCARDIAL DISEASE</u> <u>4292</u> DUE TO, OR AS A CONSEQUENCE OF - <u>SENILITY</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } (b) <u>ASCVD</u> DUE TO, OR AS A CONSEQUENCE OF (c)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>9-21-1979</u> to <u>12-20</u> 19 <u>79</u> , that (I) (we) last saw the deceased alive on <u>12-20-1979</u> and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>Alfred K. Wiedmann</u>		DEGREE <u>M.D.</u>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>12-20-1979</u>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>ALFRED K. WIEDMANN</u>		22e. ADDRESS <u>715 PARK AVE</u>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		23b. DATE <u>12/22/79</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Lorraine Park</u>		23d. LOCATION CITY OR TOWN COUNTY STATE <u>Woodlawn Baltimore, Md.</u>			
24. FUNERAL DIRECTOR NAME ADDRESS <u>MacNabb Funeral Home Catonsville, Md.</u>		25a. DATE REC'D. BY REGISTRAR <u>DEC 24 1979</u>		25b. REGISTRAR'S SIGNATURE <u>L. J. Kelly</u>					

10-1-50  
MARTIN H. HESSMAN

10-1-50  
MARTIN H. HESSMAN

10-1-50  
MARTIN H. HESSMAN

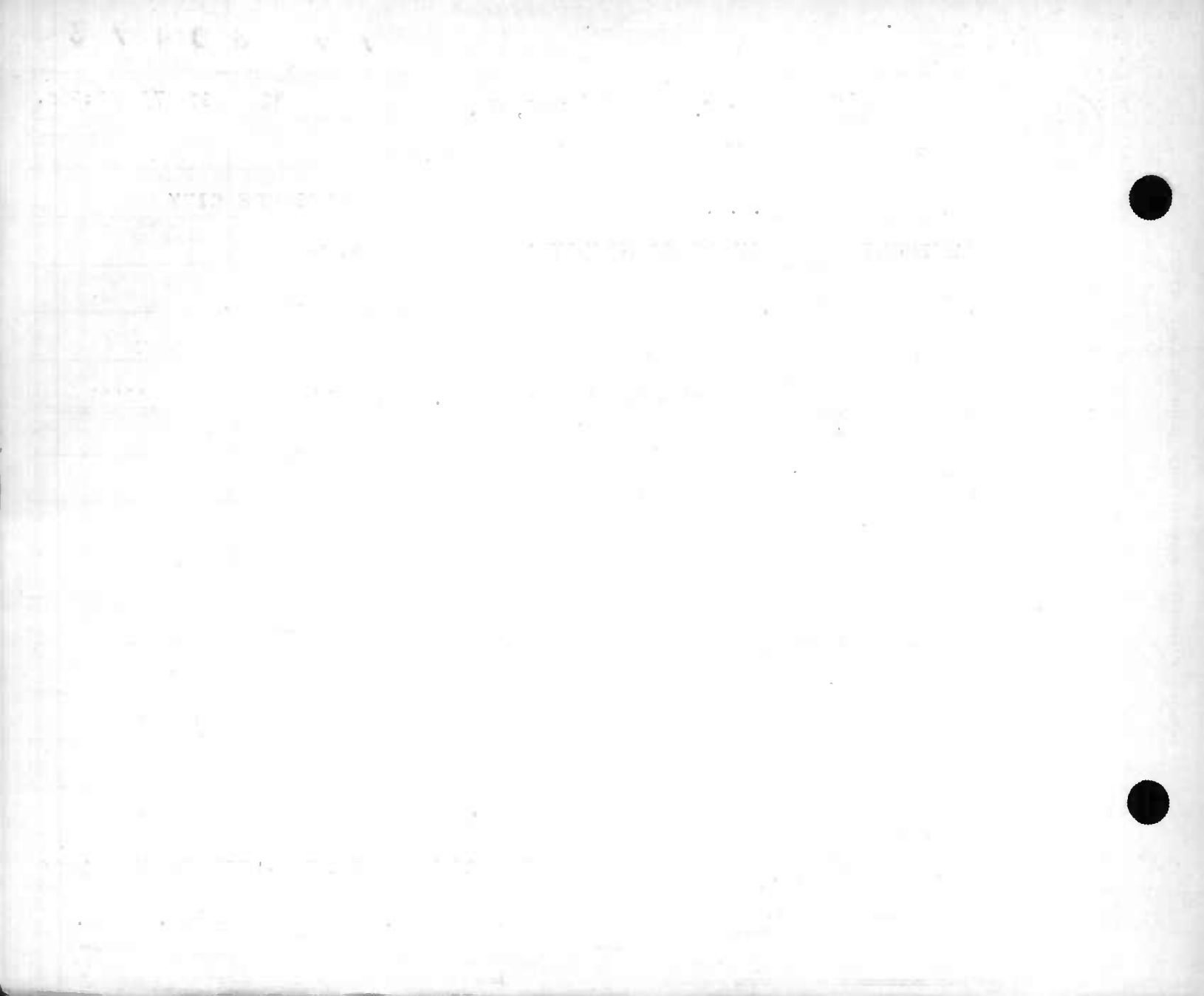
10-1-50  
MARTIN H. HESSMAN

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		7 9 3 0 1 7 3		REG. NO.					
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST JOHN E. HESS, SR.				2a. DATE OF DEATH MONTH DAY YEAR 12 11 79		2b. HOUR 7:20a. M			
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR 1 6 1906		6. AGE (IN YEARS LAST BIRTHDAY) 73 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.			
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) ST AGNES HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) CLERK		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE MARYLAND		13b. COUNTY BALTIMORE		13c. CITY OR TOWN LANSDOWNE		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 3169 Bero Road	
14. FATHER'S NAME FIRST MIDDLE LAST WILLIAM HESS				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST EMMA LLOYD					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 215-01-0412		17. INFORMANT ADDRESS THELMA H. HESS 3169 BERO ROAD 21227					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiopulmonary arrest</u> 410- DUE TO, OR AS A CONSEQUENCE OF (b) <u>Suspected acute myocardial infarct</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a):									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>[Signature]</u>				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c. DATE SIGNED 12-11-79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Kvay Nwunt, M.D.				22e. ADDRESS 900 CATON AVENUE BALTIMORE MD 21229					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 12/13/79		23c. NAME OF CEMETERY OR CREMATORY LORRAINE PARK CEMETERY		23d. LOCATION CITY OR TOWN COUNTY STATE WOODLAWN BALTO. MD.			
24. FUNERAL DIRECTOR NAME HUBBARD FUNERAL HOME				ADDRESS 4107 WILKENS AVENUE		25a. DATE REC'D. BY REGISTRAR DEC 12 1979		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	



TO HOSPITAL'S ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 79 30174	
1. DECEASED NAME (TYPE OR PRINT) <b>JOHN E. HETRICK</b>			2a. DATE OF DEATH MONTH <b>12</b> DAY <b>26</b> YEAR <b>1979</b>			2b. HOUR <b>6:25 P.M.</b>					
3. SEX <b>M Male</b>		4. RACE <b>White Caucasian</b>		5. DATE OF BIRTH MONTH <b>5</b> DAY <b>23</b> YEAR <b>27</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>52 yrs.</b>		7. IF UNDER 1 YEAR MONTHS <b></b> DAYS <b></b>		8. IF UNDER 24 HRS. HOURS <b></b> MIN. <b></b>	
9a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		9b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		10. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>CITY Baltimore City MD.</b>					
10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>GOOD SAMARITAN HOSP.</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Inspector</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Noxell Corp.</b>			
13a. STATE <b>MARYLAND</b>			13b. COUNTY <b>BALTO</b>		13c. CITY OR TOWN <b>BALTIMORE</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>Balt., Md. 21234 2501 Glencoe Rd.</b>		
14. FATHER'S NAME FIRST <b>Herbert</b> MIDDLE <b></b> LAST <b>Hetrick</b>				15. MOTHER'S MAIDEN NAME FIRST <b>Agnes</b> MIDDLE <b></b> LAST <b>Miller</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b>			16b. SOCIAL SECURITY NO. <b>215-22-5447</b>		17. INFORMANT <b>Wife:</b> <b>Laura M. Hetrick</b>		ADDRESS <b>Balt., Md. 21234 2501 Glencoe Road</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>MYOCARDIAL INFARCTION (ACUTE).</b> <b>410-</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>CARDIOGENIC SHOCK.</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>CARDIAC ARRHYTHMIA.</b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION <b></b>			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b></b>			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>12-26-79</b> , 19____, to <b>12-26-79</b> , 19____, that (I) (we) lost saw the deceased alive on <b>12-26-79</b> , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>Anusha Khianey, MD</b>						DEGREE <b>MD</b>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>12/26/79.</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>ANUSHA KHIANEY.</b>						22e. ADDRESS <b>GOOD SAMARITAN HOSPITAL.</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>Dec 29 1979</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Dulaney Valley Mem.</b>			23d. LOCATION CITY OR TOWN <b>Cockeysville</b> COUNTY <b>Maryland</b> STATE <b></b>			
24. FUNERAL DIRECTOR NAME <b>Leonard J. Ruck, Inc.</b> ADDRESS <b>Baltimore, Maryland</b>						25a. DATE REC'D. BY REGISTRAR <b>DEC 28 1979</b>		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR									
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Walter CLAY Hickey SR.						2a. DATE OF DEATH MONTH DAY YEAR 12 6 79		2b. HOUR 7:13 AM	
3. SEX M		4. RACE W		5. DATE OF BIRTH MONTH DAY YEAR 3 14 09		6. AGE (IN YEARS LAST BIRTHDAY) 70 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Baltimore		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH CITY MD.			
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) U. of Maryland				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Druck Driver		12b. KIND OF BUSINESS OR INDUSTRY Trucking	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland						13b. COUNTY A. A.		13c. CITY OR TOWN Glen Burnie	
14. FATHER'S NAME FIRST MIDDLE LAST John Andrew Hickey						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Rachel Sanders			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. 216-05-0400		17. INFORMANT Marion Hickey		ADDRESS same as above			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>cardiac arrest</u> 44/4 DUE TO, OR AS A CONSEQUENCE OF (b) <u>respiratory insufficiency</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>pseudomonas sepsis &amp; P.E.</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 wk 1 wk									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <u>Leukemia</u>									
19a. DATE OF OPERATION 11/25/79		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Abdominal aortic aneurysm				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>11/25/79</u> 19 <u>79</u> , to <u>12/6</u> 19 <u>79</u> , that (I) (we) last saw the deceased alive on <u>12/6</u> 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.									
22b. SIGNATURE Flores Mufson M.D.				DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 12/6/79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) FLORIAN MUFSON M.D.				22e. ADDRESS c/o U. of Maryland Hosp.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12/10/79		23c. NAME OF CEMETERY OR CREMATORY Glen Haven Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Glen Burnie, A.A. Md.			
24. FUNERAL DIRECTOR NAME Raymond C. Fink				ADDRESS Glen Burnie, Md.		25a. DATE REC'D. BY REGISTRAR DEC 10 1979		25b. REGISTRAR'S SIGNATURE P. Hickey	





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of the death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of the death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of page.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										7 9 3 0 1 7 6 REG. NO.	
1. FOR STATE REGISTRAR						2a. DATE OF DEATH		MONTH DAY YEAR		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>MARY HELL</b>						2a. DATE OF DEATH		MONTH DAY YEAR <b>DECEMBER 14, 1979</b>		2b. HOUR <b>7 10 PM</b>	
3. SEX <b>FEMALE</b>		4. RACE <b>BLACK</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>6 1 1979</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>70</b>		7. UNDER 1 YEAR MONTHS DAYS HOURS MIN.		8. UNDER 24 HRS MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>South Carolina</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.					
10. CITY OR TOWN OF DEATH <b>BALTO.</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>University Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE <b>Maryland</b>				13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Baltimore</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>1733 Caroline Street</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Byers Ellison</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Bertha Byers</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)				16b. SOCIAL SECURITY NO. <b>218-22-6417</b>		17. INFORMANT ADDRESS <b>Edward Byers 3036 East Federal Street</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>ASPIRATION PNEUMONIA</b> <b>436-</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>BILATERAL CVA</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>5 HOURS</b> <b>8 MONTHS</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>NOV 19 79</b> to <b>DEC 14 19 79</b> , that (I) (we) lost saw the deceased alive on <b>DECEMBER 14 19 79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) not view the body after death.											
22b. SIGNATURE <b>DAMIAN E. BIRCHES</b>				DEGREE <b>MD</b>				22c. DATE SIGNED <b>12/10/79</b>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>DAMIAN E. BIRCHES MD</b>				22e. ADDRESS <b>1000 E. EAGER ST, BALTO, MD. 21201</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>				23b. DATE <b>12/14/1979</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Westview Mem. Park</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Catonsville, Maryland</b>			
24. FUNERAL DIRECTOR NAME <b>Wm. C. March F/H 1101 East North Avenue</b>				ADDRESS <b>1101 East North Avenue</b>				25a. DATE REC'D. BY REGISTRAR <b>DEC 4 1979</b>			

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR OR PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

## MEDICAL CERTIFICATION

FOR 1- STATE REGISTRAR										DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. 30177																													
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST TRUDY KAY HILL										2a. DATE KNOWN OF DEATH ESTIMATED MONTH DAY YEAR 12 18 79										7b. HOUR M 8:20 P.M.																													
3. SEX female		4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR Feb. 24, 1954		6. AGE (IN YEARS) LAST BIRTHDAY 25 YRS.		IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		IF UNDER 24 HRS. MONTHS DAYS HOURS MIN.		2c. DATE PRONOUNCED DEAD MONTH DAY YEAR 12 18 79										8:20 P.M.																											
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland										7b. CITIZEN OF WHAT COUNTRY? USA										8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>										9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.																			
10. CITY OR TOWN OF DEATH Baltimore										11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) S.T.U. University Hospital										12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) -----										12b. KIND OF BUSINESS OR INDUSTRY -----																			
13a. STATE Maryland										13b. COUNTY Cecil										13c. CITY OR TOWN Port Deposit										13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										13e. STREET ADDRESS Md. 288 Jackson Park Rd., Port Deposit, Md.									
14. FATHER'S NAME FIRST MIDDLE LAST James H. Reeves										15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ethel Sharon (Dec)										16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No										16b. SOCIAL SECURITY NO. 215-76-4898										17. INFORMANT Address Maryland M. Kelsey Phipps, 288 Jackson Pk. Rd., Port Deposit									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Rupture thoracic aorta with massive retroperi- toneal hemorrhage (b) toneal hemorrhage (c) DUE TO, OR AS A CONSEQUENCE OF										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																																							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).																																																	
19a. DATE OF OPERATION										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?										20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>																													
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH										21b. TIME OF INJURY HOUR AM MONTH DAY YEAR 5:32 P.M. 12-18 79										21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) bicyclist struck by automobile																													
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>										21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) street										21f. LOCATION STREET CITY OR TOWN COUNTY STATE Jackson Pk. Rd. & 1/10 mt. Port Deposit, Maryland																													
22a. I certify that I took charge of the remains described above, held an death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>										Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion																																							
ACTUAL SIGNATURE H. R. Guard										TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER										DATE SIGNED 12/19/79																													
EXAMINER'S NAME (TYPE OR PRINT) Hormez R. Guard, M.D.										ADDRESS 111 Penn Street																																							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial										23b. DATE Dec. 22, 1979										23c. NAME OF CEMETERY OR CREMATORY Union Cemetery										23d. LOCATION CITY OR TOWN COUNTY STATE North East Cecil Md.																			
24. FUNERAL DIRECTOR Lee A. Patterson & Son, Perryville, Md.										25a. DATE REC'D. BY REGISTRAR DEC 28 1979										25b. REGISTRAR'S SIGNATURE																													



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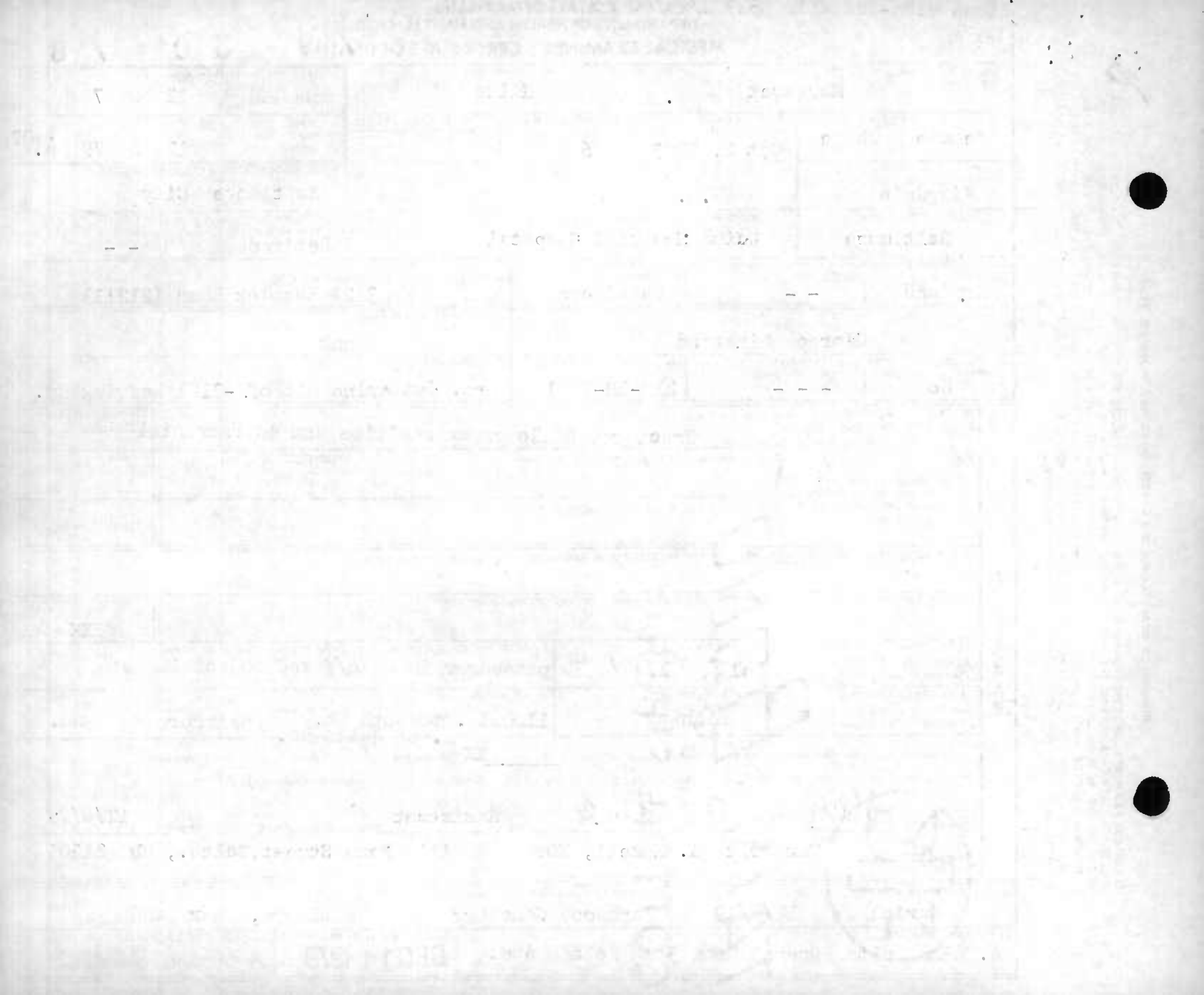
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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

Items #18a-22a Film G539 1/25/80 POSTMASTER: RETURN TO: BALTIMORE, MD. 21201										
DEPARTMENT OF HEALTH AND MENTAL HYGIENE										
MEDICAL EXAMINER'S CERTIFICATE OF DEATH										
1. DECEASED NAME (TYPE OR PRINT) <b>Margaret W. Hiltz</b>			2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH <input type="checkbox"/> DAY <input type="checkbox"/> YEAR <b>12 5 1979</b>			2b. HOUR M <b>1:07 P.M.</b>				
3. SEX <b>female</b>	4. RACE <b>white</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>Oct 2, 1893</b>	6. AGE (IN YEARS) LAST BIRTHDAY <b>86 YRS.</b>	IF UNDER 1 YR. MONTHS DAYS <b>0 0</b>	IF UNDER 24 HRS. HOURS MIN <b>0 0</b>	2c. DATE PRONOUNCED DEAD MONTH DAY YEAR <b>12 5 1979</b>		2d. HOUR M <b>1:07 P.M.</b>		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Virginia</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.				
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Union Memorial Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Retired</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>- -</b>		
13a. STATE <b>Maryland</b>			13b. COUNTY <b>- -</b>		13c. CITY OR TOWN <b>Baltimore</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>3121 Keswick Road (21211)</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>George Winstead</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>unk</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>No</b>			16b. SOCIAL SECURITY NO. <b>219-10-7761</b>		17. INFORMANT ADDRESS <b>Mrs. Catherine Althoff-3121 Keswick Rd.</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Fractures of lower extremities and intracranial hemorrhages</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) <b>hemorrhages</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>8151</b>										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?					20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR MONTH DAY YEAR <b>5:15 P.M. 12/3/79</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) <b>passenger in auto/fixed object impact</b>					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <b>highway</b>		21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b>1100blk. to 36th St. Baltimore Md.</b>					
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .										
ACTUAL SIGNATURE <b>Margareta A. Korell</b>			TITLE (SPECIFY) <b>Assistant</b>			MEDICAL EXAMINER		DATE SIGNED <b>12/6/79</b>		
EXAMINER'S NAME (TYPE OR PRINT) <b>Margarita A. Korell, MD.</b>			ADDRESS <b>111 Penn Street, Balto., MD 21201</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>12/8/79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Parkwood Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore, Maryland</b>			
24. FUNERAL DIRECTOR NAME ADDRESS <b>A. Alan Seitz Funeral Home 3818 Roland Ave.</b>					25a. DATE REC'D. BY REGISTRAR <b>DEC 11 1979</b>		25b. REGISTRAR'S SIGNATURE <b>Anthony A. Brady</b>			



DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

7 9 3 0 1 7 9

REG. NO.

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>JOHN C. HIMMER, JR</b>			2a. DATE OF DEATH MONTH <b>12</b> DAY <b>7</b> YEAR <b>79</b>			2b. HOUR <b>545 AM</b>					
SEX <b>MALE</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH <b>6</b> DAY <b>1</b> YEAR <b>14</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>65</b> YRS					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALT CITY</b> MD					
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Baltimore City Hospitals</b>				12a. KIND OF BUSINESS OR INDUSTRY (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Carpenter Foreman</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Beth. Steel</b>			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE <b>Maryland</b> COUNTY <b>Baltimore</b>			13b. CITY OR TOWN <b>Dundalk</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>6907 Railway Avenue</b>				
14. FATHER'S NAME FIRST <b>John</b> MIDDLE <b>C.</b> LAST <b>Himmer, Sr.</b>			15. MOTHER'S MAIDEN NAME FIRST <b>Helen</b> MIDDLE <b>R.</b> LAST <b>Herget</b>			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>			16b. SOCIAL SECURITY NO. <b>213-07-6514</b>		
17. INFORMANT <b>Bertha M. Himmer</b>			17. ADDRESS <b>6907 Railway Ave. Balto. MD 21222</b>								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIAC ARREST</b> <b>1911</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>RIGHT FRONTAL ASTROCYTOMA</b> DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>Richard T. McLaughlin MD</b>						DEGREE <b>MD</b>			22c. DATE SIGNED <b>12/7/79</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>RICHARD T. MCGLAUGHLIN</b>						22e. ADDRESS <b>4940 EASTERN AVE, BALT. MD.</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>12/10/79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Oak Lawn Cemetery</b>			23d. LOCATION CITY OR TOWN <b>Baltimore</b> COUNTY <b>Baltimore</b> STATE <b>MD</b>			
24. FUNERAL DIRECTOR NAME <b>Duda-Ruck, Inc.</b> ADDRESS <b>7922 Wise Avenue, Dundalk, MD 21222</b>						25a. DATE REC'D BY REGISTRAR <b>DEC 11 1979</b>					

MEDICAL CERTIFICATION

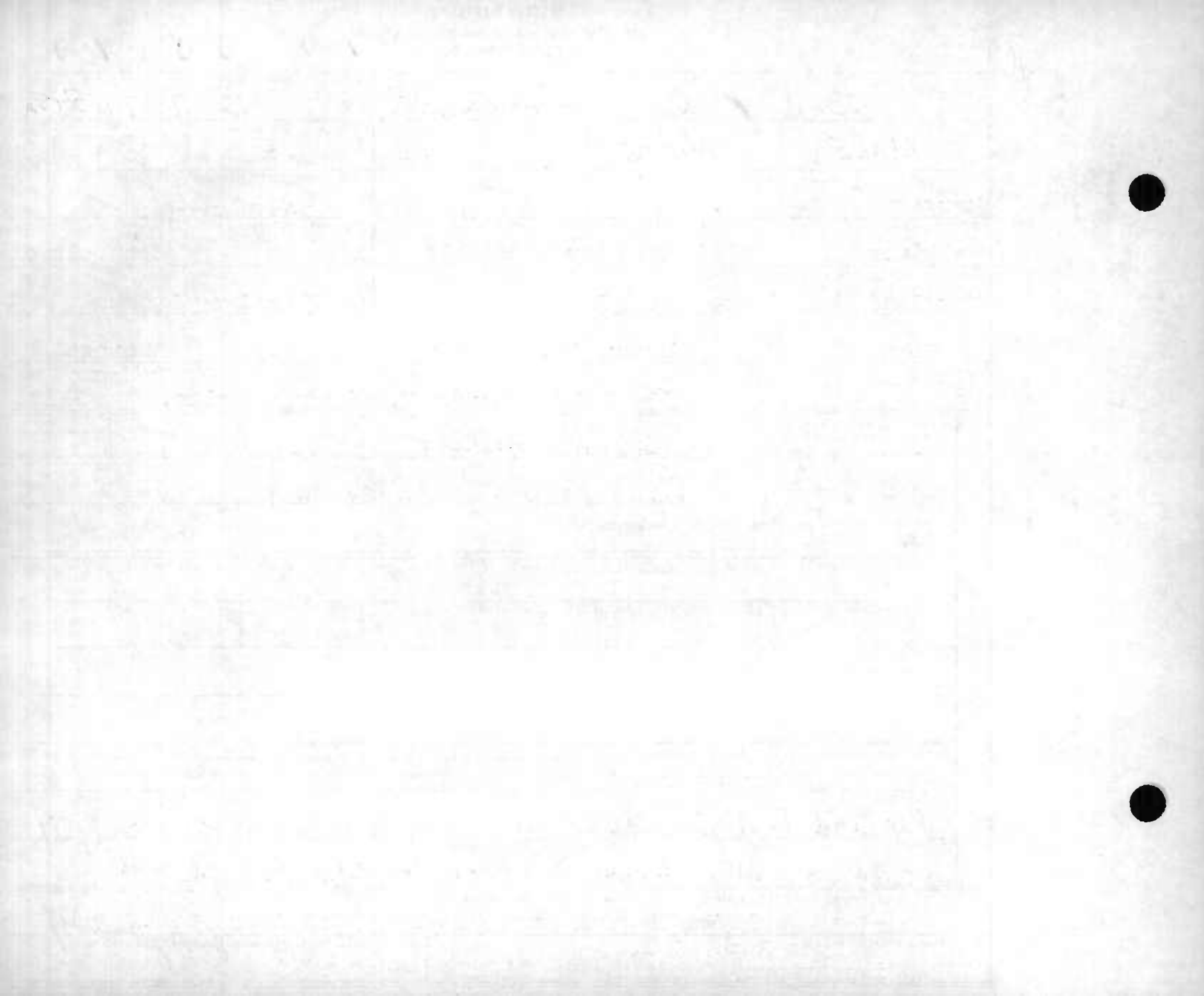
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

BP \_\_\_\_\_







2

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

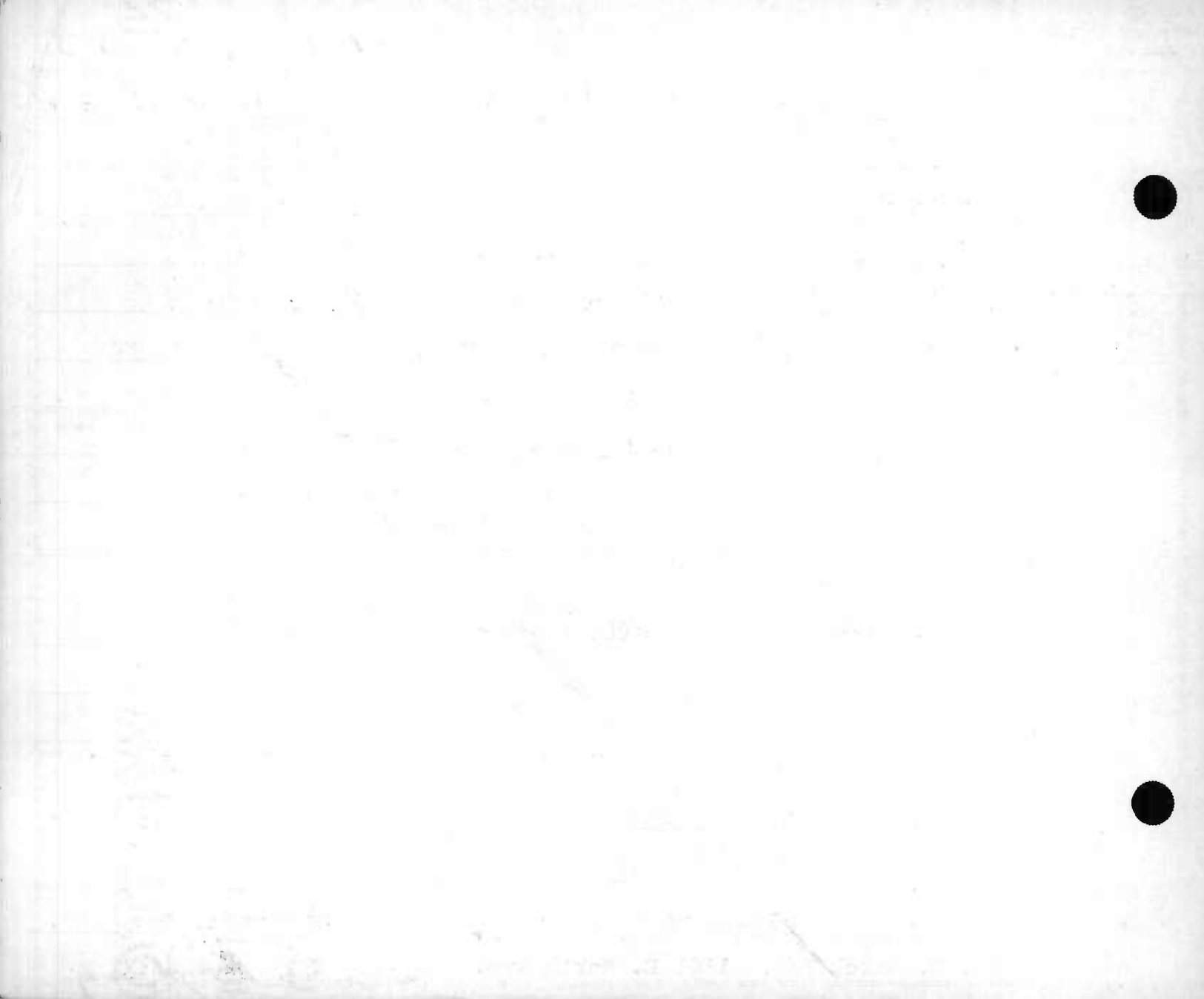
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										7 9 3 0 1 8 0 REG. NO.			
1. FOR STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT) CLARENCE A HINES				2a. DATE OF DEATH MONTH DAY YEAR 12 22 '79				2b. HOUR 3 P.M.			
3 SEX Male		4 RACE B		5. DATE OF BIRTH MONTH DAY YEAR 11- 6 90		6 AGE (IN YEARS LAST BIRTHDAY) 89 YRS		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.							
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) LUTHERAN HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY					
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 2101 WHITTIER					
14. FATHER'S NAME FIRST MIDDLE LAST CHARLES H. HINES, SR.				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MATILDA SNOWDEN									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 218-01-3827		17. INFORMANT ADDRESS MORSELL HINES 2106 Whittier Ave.									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardioresp. arrest 185- Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Metastatic Carcinoma of prostate (c) DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a):													
19a. DATE OF OPERATION 12/4/79		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Pelvic mass				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that (this hospital) attended the deceased from 11/26/79, 19____, to 12/22/79, 19____, that (we) last saw the deceased alive on 12/22/79, and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE R. Thiaga Rajan M.D.						DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 12/22/79					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) R. THIAGARAJAN M.D.						22e. ADDRESS							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12/26-79		23c. NAME OF CEMETERY OR CREMATORY MT. CALVARY CEM		23d. LOCATION CITY OR TOWN COUNTY STATE Anne Arundel Co., Md.							
24. FUNERAL DIRECTOR NAME Wm. C. March F/H,						ADDRESS 1101 E. North Ave.		25a. DATE REC'D. BY REGISTRAR DEC 26 1979		25b. REGISTRAR'S SIGNATURE R. Thiaga Rajan			

BP

DHMM-16 20M  
(VRA 15, 4) 7/78

1504



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, THE EXAMINER SHOULD EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE FORMS 1, 2, AND 3 TO THE FUNERAL DIRECTOR. GIVE FORM 4 TO THE CHIEF MEDICAL EXAMINER. ALONG WITH FORM PM 3, RETAIN PAGE 5 FOR YOUR RECORDS. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 30181			
1. FOR STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST MORRA E. HINES						2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR 12 17 79		2b. HOUR M 8:25 a			
3. SEX male		4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR Aug 14, 1901		6. AGE (IN YEARS) LAST BIRTHDAY 78 YRS.		IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		2c. DATE PRONOUNCED DEAD MONTH DAY YEAR 12 17 79			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) West Virginia				7b. CITIZEN OF WHAT COUNTRY? U.S.A.				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.			
10. CITY OR TOWN OF DEATH Baltimore				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 4609 Bayonne Ave.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired Barber		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE Maryland				13b. COUNTY Baltimore		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 4609 Bayonne Ave					
14. FATHER'S NAME FIRST MIDDLE LAST John Morra Hines				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST xwx Emma ?									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 217-32-9729		17. INFORMANT Mrs Alyce J Hines				ADDRESS Same			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia 486- DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (c) stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a). Cirrhosis													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .													
ACTUAL SIGNATURE Ann M. Dixon, M.D.						TITLE (SPECIFY) M.D. Assistant			MEDICAL EXAMINER			DATE SIGNED 12-17-79	
EXAMINER'S NAME (TYPE OR PRINT) Ann M. Dixon, M.D.				ADDRESS 111 Penn St.									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 12/19/79		23c. NAME OF CEMETERY OR CREMATORY Gardens Of Faith				23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Maryland			
24. FUNERAL DIRECTOR NAME Leonard J Ruck Inc. Baltimore, Maryland						25a. DATE REC'D. BY REGISTRAR DEC 18 1979		25b. REGISTRAR'S SIGNATURE Anthony McCreedy					



CONFIDENTIAL

STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

7 9 30182

1 - FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>RUTH SADIE ELIZABETH HINTON</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>DEC. 12 18 79</b>			2b. HOUR <b>945 AM</b>	
3. SEX <b>FEMALE</b>		4. RACE <b>Black</b>		5. DATE OF BIRTH DAY MONTH YEAR <b>03 01 1921</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>58</b> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MO.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.	
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>SOUTH BALTIMORE GENERAL</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>NONE</b>	
12b. KIND OF BUSINESS OR INDUSTRY <b>NONE</b>		13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>MD</b> 13b. COUNTY <b>BALT.</b> 13c. CITY OR TOWN <b>BALT.</b> 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> 13e. STREET ADDRESS <b>1213 LIGHT ST BALTO, MD</b> (21230)					
14. FATHER'S NAME FIRST MIDDLE LAST <b>DAAM B BRISCOE</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>VIRGINIA BOLLING</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>214-20-7280</b>		17. INFORMANT ADDRESS <b>ROBERT BRISCO 1401 CARSWELL DR PH. 242 0129</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>CHRONIC RENAL INSUFFICIENCY</b> <b>2503</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>DIABETIC NEPHROPATHY</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a). <b>CONGESTIVE HEART FAILURE / BUNOWESS</b>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>8/31/79</b> , 19____, to <b>12/18/79</b> , 19____, that (I) (we) last saw the deceased alive on <b>12/18/79</b> , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>J. Calisher</b>				DEGREE <b>M.D.</b> ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>12/18/79</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>JORGE E. CLOONEY</b>				22e. ADDRESS <b>3001 So. Hanover St, Balt</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>12/22/79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Pleasant Rest</b>		23d. LOCATION <b>Towson Balto MD</b>	
24. FUNERAL DIRECTOR NAME <b>Marshall W Jones Jr/4101 Edmondson Ave</b>				25a. DATE REC'D. BY REGISTRAR <b>DEC 24 1979</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examination must be noted at once.

2-6-100

C. M. B. J. J. J.

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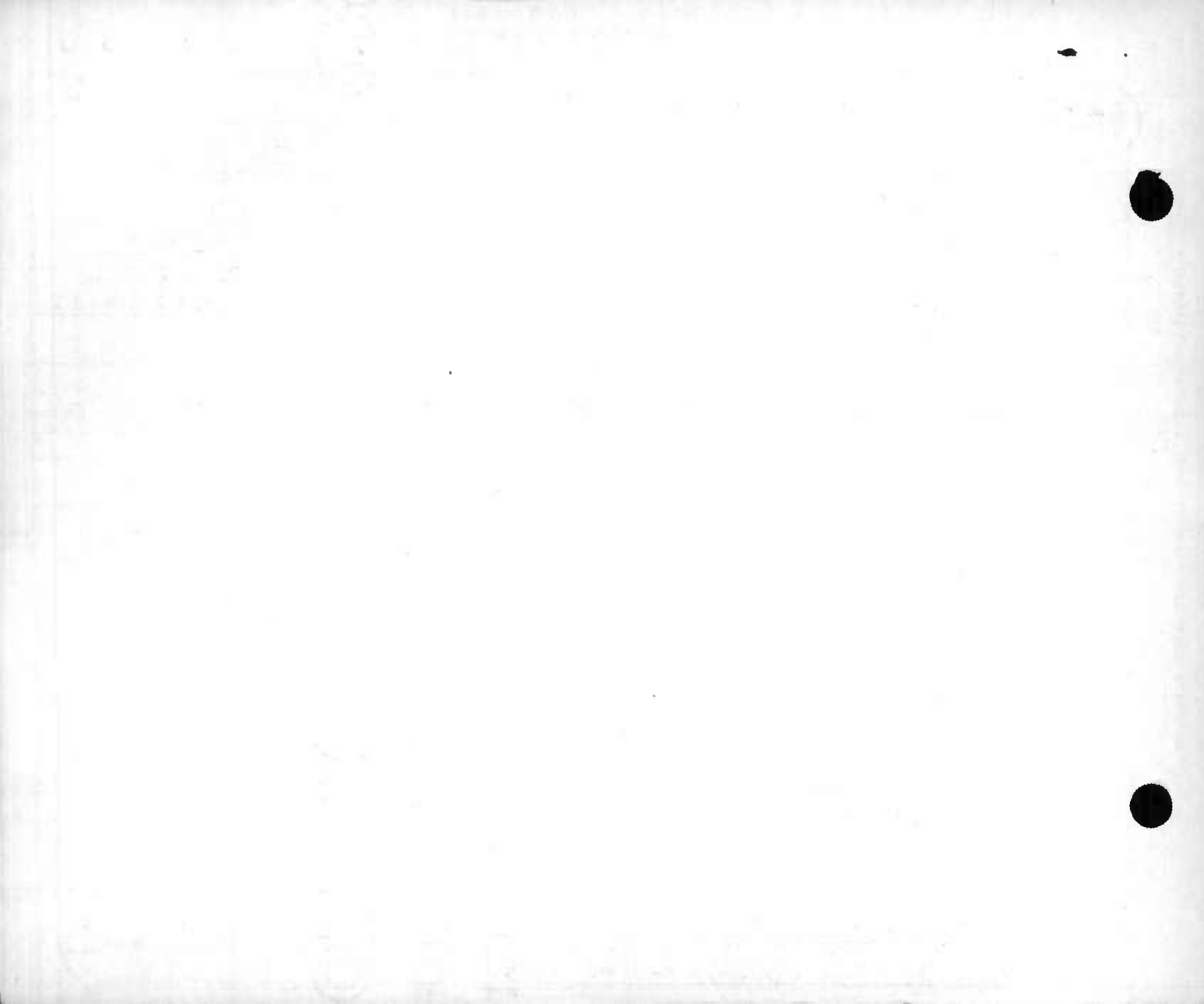
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		7 9 3 0 1 8 3 REG. NO.							
1. DECEASED NAME (TYPE OR PRINT)		FIRST RAYMOND		MIDDLE H.		LAST HISCOCK		2a. DATE OF DEATH MONTH DAY YEAR 12 14 79	
3. SEX M		4. RACE W		5. DATE OF BIRTH MONTH DAY YEAR 8 27 05		6. AGE (IN YEARS LAST BIRTHDAY) 74 YRS		7b. HOUR 2:58 P.M.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York SA		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltco. city		10. MONTHS OAYS HOURS MIN.	
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Sinai Hosp.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired - Accountant		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Maryland		13b. COUNTY Baltco.		13c. CITY OR TOWN Randallstown		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 4 Albess Ct. Apt 2 21133	
14. FATHER'S NAME FIRST MIDDLE LAST Unknown		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Unknown							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) —		17. INFORMANT Robert Hiscock		ADDRESS 3812 Brownhill Rd. 21133			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cardiorespiratory arrest 1489 DUE TO, OR AS A CONSEQUENCE OF (b) Aspiration bacterial pneumonia DUE TO, OR AS A CONSEQUENCE OF (c) Cancer of hypopharynx								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 days 9 mos.	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) Cirrhosis of liver, chronic obstructive lung disease, obesity									
19a. DATE OF OPERATION N/A		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (this hospital) attended the deceased from Nov. 21, 1979, to Dec. 14, 1979, that (I) <input checked="" type="checkbox"/> lost saw the deceased alive on Dec. 14, 1979, and that in (my) <input checked="" type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above, (I) <input checked="" type="checkbox"/> (did) <input checked="" type="checkbox"/> (did not) view the body after death									
22b. SIGNATURE Burt Ira Feldman		DEGREE				ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 12-14-79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) BURT IRA FELDMAN				22e. ADDRESS 6410-A Elray Drive, Baltco. MD 21209					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12/17/79		23c. NAME OF CEMETERY OR CREMATORY Westview Mem. Park		23d. LOCATION CITY OR TOWN Catonsville		23e. COUNTY BALT	
24. FUNERAL DIRECTOR NAME Loring Byers Funeral Directors PA		8728 Liberty Rd		ADDRESS Randallstown		25a. DATE RECEIVED BY REGISTRAR DEC 18 1979		25b. REGISTERING PHYSICIAN Signature	

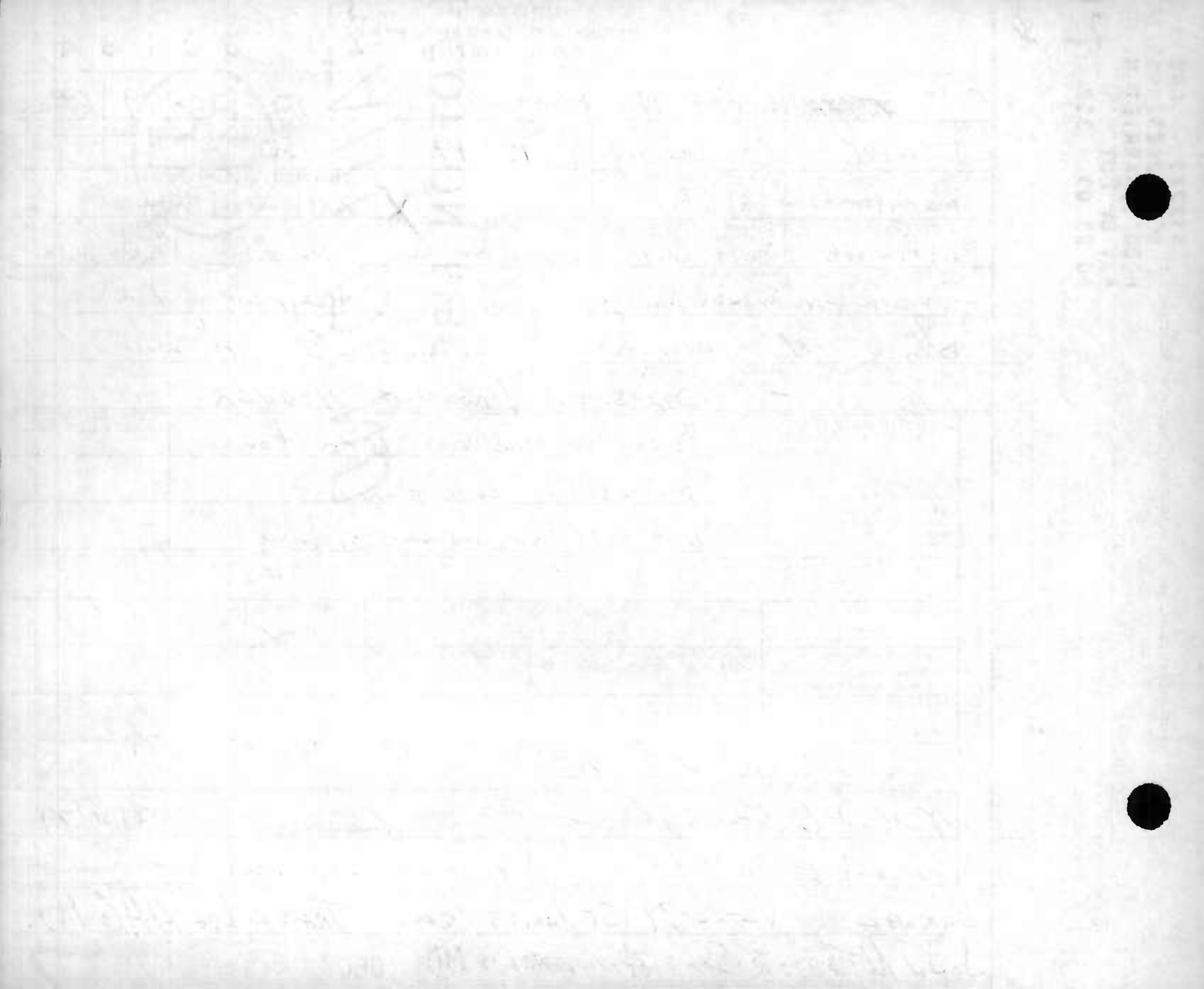




STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										7 9 3 0 1 8 4 REG. NO.							
1. FOR STATE REGISTRAR										2a. DATE OF DEATH MONTH DAY YEAR				2b. HOUR			
1. DECEASED NAME FIRST MIDDLE LAST <del>Harriet N. Hodges</del> Harriet N. Hodges										12-20-79				6:20 a.m.			
3 SEX Female			4 RACE Caucasian			5. DATE OF BIRTH MONTH DAY YEAR 9 15 17			6 AGE (IN YEARS LAST BIRTHDAY) 62 YRS			IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.			
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland			7b CITIZEN OF WHAT COUNTRY? USA			8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.								
10 CITY OR TOWN OF DEATH Baltimore			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Balt. Cancer Research Program							12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Nurse			12b KIND OF BUSINESS OR INDUSTRY Public Health Nurse				
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)										13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				13e STREET ADDRESS 402 Montevue Ave.			
13a. STATE Maryland			13b. COUNTY Annapolis			13c. CITY OR TOWN Annapolis											
14. FATHER'S NAME FIRST MIDDLE LAST Daniel N. Armiger					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Gertrude E. Hilson												
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) -			17 INFORMANT VIRGINIA HOOVER			ADDRESS								
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1629 Cerebellar tonsillar herniation DUE TO, OR AS A CONSEQUENCE OF (b) Metastatic carcinoma DUE TO, OR AS A CONSEQUENCE OF (c) oat cell carcinoma of lung										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																	
19a DATE OF OPERATION -			19b CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE											
22a. I certify that (I) (this hospital) attended the deceased from June 30, 1977, to Dec. 20, 1979, that (I) (we) lost saw the deceased alive on Dec. 20, 1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																	
22b. SIGNATURE Robert E. Gallagher					DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>					22c. DATE SIGNED 12/20/79							
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Robert E. Gallagher					22e. ADDRESS Baltimore Cancer Research Program												
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 12-22-79			23c. NAME OF CEMETERY OR CREMATORY St James Cem.			23d. LOCATION CITY OR TOWN COUNTY STATE Tracys Loc PPA Co MD.								
24. FUNERAL DIRECTOR NAME John M Taylor Sons Annapolis MD					25a. DATE REC'D. BY REGISTRAR DEC 24 1979					25b. REGISTRAR'S SIGNATURE Anthony M Brady							

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours of death. Page may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

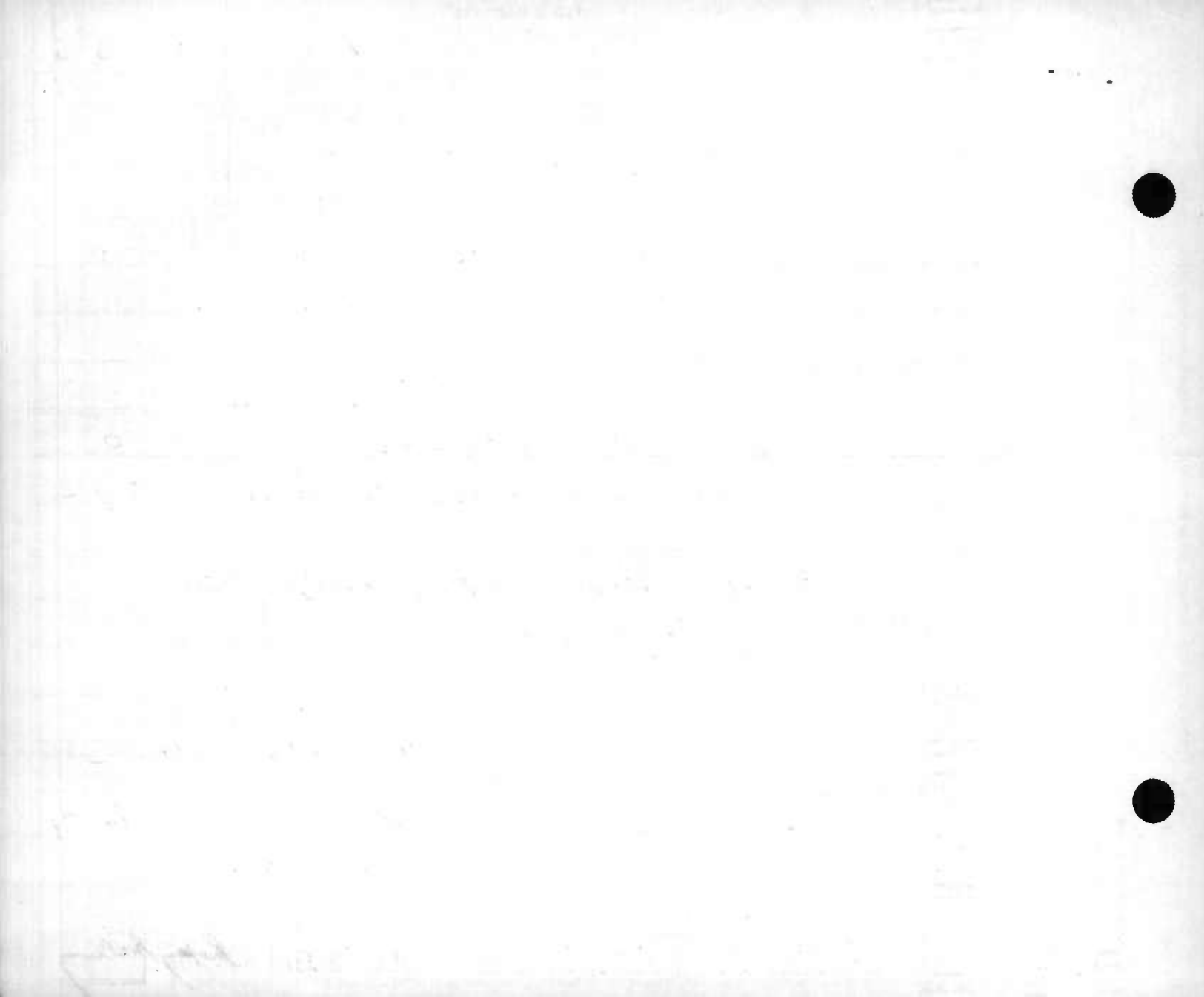


TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR STATE REGISTRAR				STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				7 9 3 0 1 8 5 REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) IRIS HOHMAN				2a. DATE OF DEATH MONTH DAY YEAR DECEMBER 6, 1979				2b. HOUR A. 8:20 AM			
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR JAN. 24, 1902		6. AGE (IN YEARS LAST BIRTHDAY) 77 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) RUSSIA		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.					
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 2216 KEN OAK RD., 2ND FL.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) MERCHANT		12b. KIND OF BUSINESS OR INDUSTRY RETAIL			
13a. STATE MARYLAND		13b. COUNTY BALTIMORE		13c. CITY OR TOWN BALTIMORE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 101 E. READ ST. #21202			
14. FATHER'S NAME FIRST MIDDLE LAST MAX MILLER				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ANNA JAFFE							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO 217-01-1869		17. INFORMANT MRS. DIANE MARKMAN ADDRESS 2216 KEN OAK RD. BALTO., MD 21209							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>RESPIRATORY FAILURE</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>(ADENOCARCINOMA) METASTATIC CANCER of the COLON</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>1539</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>2 yrs</u>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>ASCVD - Atrial Fibrillation, benign goiter</u>											
19a. DATE OF OPERATION <u>10/5/79</u>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>CA of COLON</u>				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <u>11/23</u> 19 <u>79</u> to <u>12/6</u> 19 <u>79</u> , that (I) (we) lost saw the deceased alive on <u>11/23</u> 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>Abraham Genecin</u>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED <u>12/6/79</u>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DR. ABRAHAM GENECIN				22e. ADDRESS 611 PARK AVE. BALTO., MD							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE DEC. 9, 1979		23c. NAME OF CEMETERY OR CREMATORY HEBREW FRIENDSHIP		23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE MARYLAND					
24. FUNERAL DIRECTOR SOL LEVINSON & BROS., INC. NAME ADDRESS 6010 REISTERSTOWN RD. BALTO., MD 21215						25a. DATE REC'D. BY REGISTRAR DEC 13 1979		25b. REGISTRAR'S SIGNATURE <u>Barry McBrady</u>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

30186

1. DECEASED NAME (TYPE OR PRINT) <b>HUBIE L. Holcomb</b>			2a. DATE OF DEATH MONTH <b>12</b> DAY <b>13</b> YEAR <b>79</b>			2b. HOUR <b>1:15 P.M.</b>				
3 SEX <b>MALE</b>		4 RACE <b>BLACK</b>		5. DATE OF BIRTH MONTH <b>9</b> DAY <b>2</b> YEAR <b>18</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>61</b> YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Virginia</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City, MD.</b>				
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>UNIVERSITY HOSPITAL</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Chauffeur</b>		12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE <b>Maryland</b>			13b. COUNTY		13c. CITY OR TOWN <b>Baltimore</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>1612 W. Saratoga Street</b>	
14. FATHER'S NAME FIRST <b>West</b> MIDDLE LAST <b>Holcomb</b>			15. MOTHER'S MAIDEN NAME FIRST <b>Mabel</b> MIDDLE LAST <b>Holcomb</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>yes</b>			16b. SOCIAL SECURITY NO. <b>214-18-3345</b>		17. INFORMANT ADDRESS <b>Mildred Coley 1612 W. Saratoga St.</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>ELECTROLYTE IMBALANCE</b> <b>1419</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>CARCINOMA OF TONGUE AND NECK</b> DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a): <b>POOR RESPIRATORY FUNCTION - ATELECTASIS, PNEUMONIA</b>										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>12/11</b> , 19 <b>79</b> , to <b>12/13/79</b> , 19 <b>79</b> , that (I) (we) last saw the deceased alive on <b>12/13</b> , 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <b>Louis H. Cohen M.D.</b>					DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>12/13/79</b>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>LOUIS H. COHEN M.D.</b>					22e. ADDRESS <b>UNIVERSITY Hosp.</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>12-18-79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Md. Veterans' Cem. Cheltenham</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Md.</b>			
24. FUNERAL DIRECTOR NAME <b>Charles A. Rice, P.A. 1300 Eutaw Pl.</b>					25a. DATE REC'D. BY REGISTRAR <b>DEC 21 1979</b>		25b. REGISTRAR'S SIGNATURE <b>Rickey McCreedy</b>			



Baltimore City

Chapman

James M. Chapman

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STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

79 30188

1 - FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>WALLACE M. HOLEMAN</b>			2a. DATE OF DEATH MONTH <b>12</b> DAY <b>3</b> YEAR <b>79</b>		2b. HOUR <b>535</b> M
3. SEX <b>Male</b>	4. RACE <b>Negro</b>	5. DATE OF BIRTH MONTH <b>9</b> DAY <b>7</b> YEAR <b>1933</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>46</b> YRS	IF UNDER 1 YEAR MONTHS <b></b> DAYS <b></b>
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Virginia</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore</b> MD.	
10. CITY OR TOWN OF DEATH <b>Baltimore</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Provident Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Baltimore</b>	13c. CITY OR TOWN <b>Baltimore</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST <b>Bennie</b> MIDDLE <b>W.</b> LAST <b>Holeman</b>		15. MOTHER'S MAIDEN NAME FIRST <b>Lillie</b> MIDDLE <b>B.</b> LAST <b>Crowder</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>226-36-1169</b>		17. INFORMANT ADDRESS <b>Elizabeth Stovall 2707 Uhler Avenue</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: <b>2391</b> IMMEDIATE CAUSE (a) <b>ACUTE MYOCARDIAL INFARCTION</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>LEFT PNEUMONECTOMY 11/30/79</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>NECROTIC TUMOR OF THE LEFT LUNG</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>ONE HOUR</b>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).					
19a. DATE OF OPERATION <b>11/30/79</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>NECROTIC TUMOR OF LEFT LUNG</b>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>11/25/79</b> to <b>12/3/79</b> , that (I) (we) last saw the deceased alive on <b>12/3/79</b> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>GARTH A.S. SAMUELS</b> MD				22c. DATE SIGNED <b>12/3/79</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>GARTH A.S. SAMUELS</b>				22e. ADDRESS <b>6911 PARK HEIGHTS AVE BALTIMORE MD 21215</b>	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>	23b. DATE <b>12/7/1979</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Church Cemetery</b>		23d. LOCATION CITY OR TOWN <b>South Boston</b> COUNTY <b>Virginia</b> STATE <b></b>	
24. FUNERAL DIRECTOR NAME <b>Wm. C. March F/H 1101 East North Avenue</b>				25a. DATE REC'D. BY REGISTRAR <b>DEC 5 1979</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

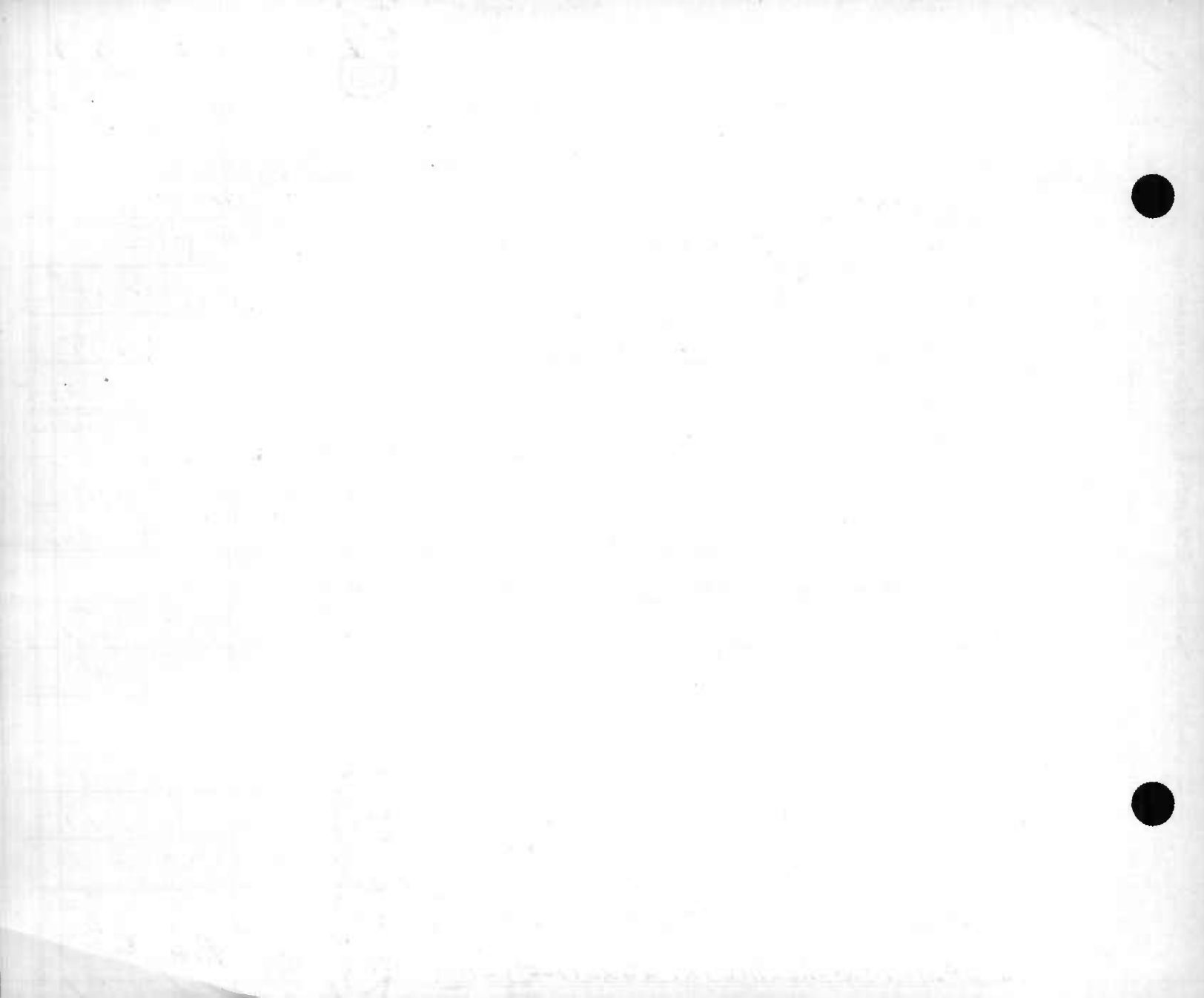
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										79 30189 REG. NO.		
1. FOR STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST	2a. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR
		CECELIA				HOHEWINSKI	12		11	1979		1130 AM
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS		
F		W		11 11 07		72 YRS		MONTHS		DAYS		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH						
POLAND		USA				BALTIMORE CITY MD.						
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		
BALTIMORE		UNIVERSITY MARYLAND						HOUSEWIFE				
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS				
MD				BALTIMORE		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		314 S. EIRIND STREET				
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS				
STANLEY		JEDREJCZAK						LORRAINE BROWN 9818 KERRIGAN CT.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a):										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
3580 RESPIRATORY FAILURE										DAYS		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										11/13/79		
(b) MYOCARDIAL INFARCTION & CEREBRAL ANOXIA										10 YEARS		
(c) MYASTHENIA GRAVIS												
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):												
RHEUMATOID ARTHRITIS, THYROID DISEASE												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?				
						YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)								
		HOUR A.M. MONTH DAY YEAR										
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION		CITY OR TOWN		COUNTY		STATE		
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>												
22a. I certify that (I) (this hospital) attended the deceased from 11/13/79 to 12/1/79, 1979, that (I) (we) last saw the deceased alive on 12/1/79, 1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE		DEGREE						22c. DATE SIGNED				
Richard D. Wagon, M.D.		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>						12/1/79				
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS										
R. F. MAYER		UNIVERSITY MARYLAND HOSPITAL										
23a. BURIAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION		CITY OR TOWN		COUNTY STATE		
BURIAL		12/5/79		ST. STANISLAUS CEM.		BALTIMORE				MD		
24. FUNERAL DIRECTOR		24b. ADDRESS		24c. DATE REC'D. BY REGISTRAR		24d. REGISTRAR'S SIGNATURE						
RAYMOND L. KACZOROWSKI		2525 FLEET ST.		DEC 4 1979		[Signature]						



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 30190	
1- STATE REGISTRAR											
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST HOWARD S HOLLEY							2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR 12 9 1979		2b. HOUR M 3:32 p.m.		
3. SEX male		4. RACE negro		5. DATE OF BIRTH MONTH DAY YEAR 3/5/02		6. AGE (IN YEARS) (LAST BIRTHDAY) YRS. 77		7c. DATE PRONOUNCED DEAD MONTH DAY YEAR 12 9 1979		7d. HOUR p.m.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Phil. Pa.			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.		
10. CITY OR TOWN OF DEATH Baltimore			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1435 N. Fulton Ave.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Crane Operator			12b. KIND OF BUSINESS OR INDUSTRY B & O R.R.	
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE Md.		13b. COUNTY City		13c. CITY OR TOWN Balto.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 1435 N. Fulton Ave.			
14. FATHER'S NAME FIRST MIDDLE LAST Alfred D. Holley						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Anna M. Stokes					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No				16b. SOCIAL SECURITY NO. 705-10-6311		17. INFORMANT ADDRESS Horace Cole 2618 W. Lafayette Ave.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive heart failure 4280 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE <i>Ann M. Dixon</i>				TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER				DATE SIGNED 12-10-79			
EXAMINER'S NAME (TYPE OR PRINT) Ann M. Dixon, M.D.				ADDRESS 111 Penn St.							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 12/13/79		23c. NAME OF CEMETERY OR CREMATORY Arbutus Mem. Park			23d. LOCATION CITY OR TOWN COUNTY STATE Arbutus Balto Md.			
24. FUNERAL DIRECTOR NAME Charles A. Rice ADDRESS 1300 Eutaw Place						25a. DATE REC'D. BY REGISTRAR DEC 17 1979		25b. REGISTRAR'S SIGNATURE <i>Robert A. [Signature]</i>			

RECEIVED  
FEDERAL BUREAU OF INVESTIGATION  
U. S. DEPARTMENT OF JUSTICE  
WASHINGTON, D. C. 20535

TO : SAC, NEW YORK  
FROM : SAC, NEW YORK  
SUBJECT: [Illegible]

RE: [Illegible]  
[Illegible]

On [Illegible] [Illegible]  
[Illegible]

[Illegible]

[Illegible]

[Illegible]

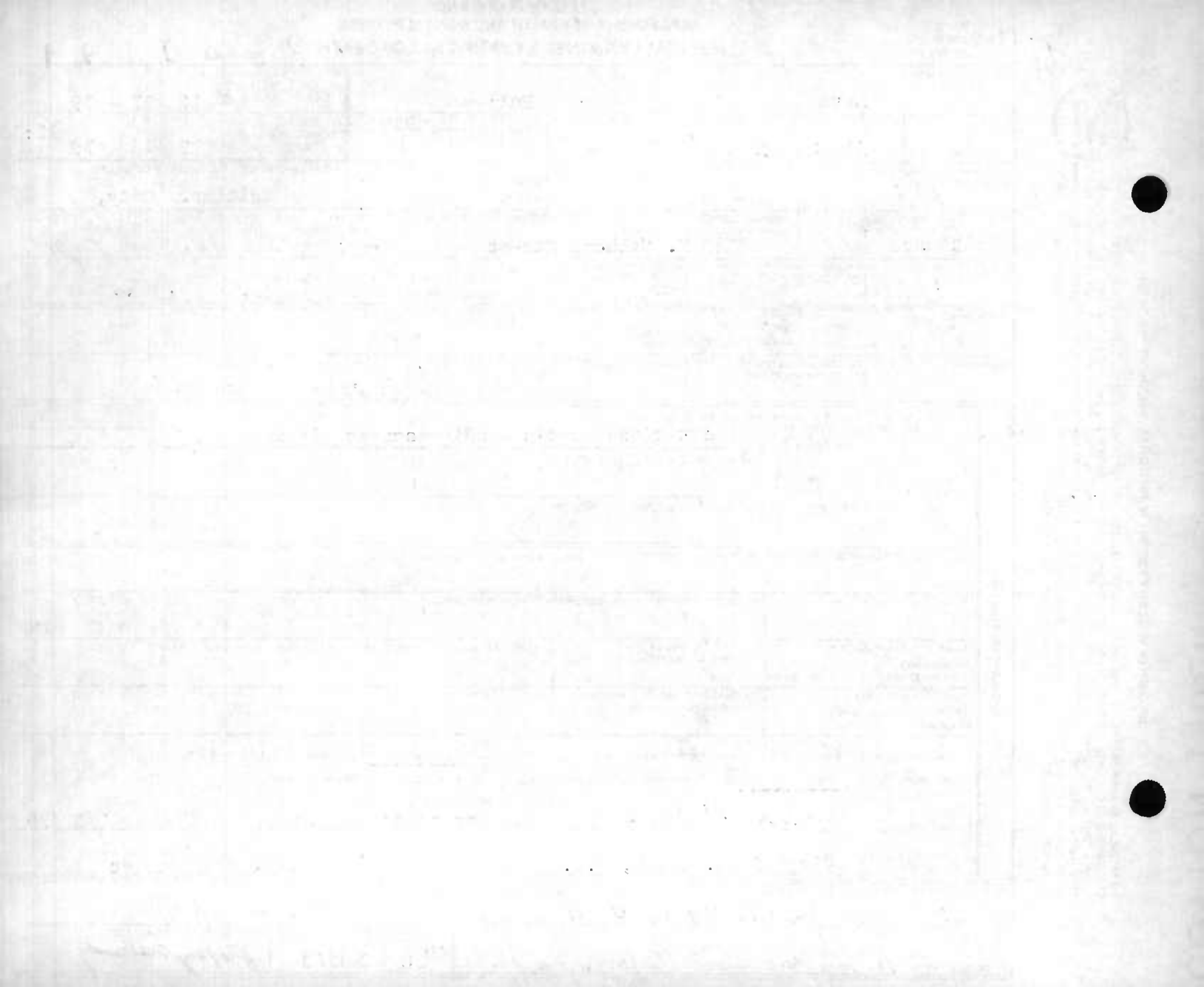
[Illegible]

[Illegible]

Very truly yours,  
[Illegible]  
Special Agent in Charge

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL HOME. GIVE PAGE 4 TO THE FUNERAL DIRECTOR. PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

FOR 1- STATE REGISTRAR		STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH				REG. NO. 30191	
1. DECEASED NAME (TYPE OR PRINT) Levi Holley				2a. DATE KNOWN OF DEATH ESTIMATED 12 17 19 79		2b. HOUR 12:10 A M	
3. SEX Male	4. RACE Black	5. DATE OF BIRTH MONTH DAY YEAR 12-8-1895	6. AGE (IN YEARS) LAST BIRTHDAY 84 YRS.	IF UNDER 1 YR. MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN	2c. DATE PRONOUNCED DEAD 12 18 19 79	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City, MD.	
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1140 N. Calhoun Street			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) RET. - GOVERNMENT EMPLOY.		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE Md.		13b. COUNTY	13c. CITY OR TOWN BALTO.	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS 1140 CALHOUN ST.		
14. FATHER'S NAME FIRST MIDDLE LAST Wm. Holley				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ROSIE			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS ALBERTA WEEKS SAME			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Cardiovascular Disease 4292 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .							
ACTUAL SIGNATURE Virginia L. Dolan MD		TITLE (SPECIFY) Assistant		MEDICAL EXAMINER		DATE SIGNED 12/18/79	
EXAMINER'S NAME (TYPE OR PRINT) Virginia L. Dolan, M.D.		ADDRESS 111 Penn Street					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12-22-79	23c. NAME OF CEMETERY OR CREMATORY Mt. Auburn Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE BALTO., MD.		
24. FUNERAL DIRECTOR NAME Vernon R. Bailey		ADDRESS 1348 Calhoun St.		25a. DATE REC'D. BY REGISTRAR DEC 18 1979		25b. REGISTRAR'S SIGNATURE Fitzroy Melby	





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
1. FOR STATE REGISTRAR											
1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>JOSEPH LEO HOLMES</b>						2a DATE OF DEATH MONTH DAY YEAR <b>12 22 79</b>			2b HOUR <b>8:20PM</b>		
3. SEX <b>MALE</b>		4 RACE <b>WHITE</b>		5 DATE OF BIRTH MONTH DAY YEAR <b>7 10 23</b>		6 AGE (IN YEARS LAST BIRTHDAY) YRS <b>56</b>			7 IF UNDER 1 YEAR IF UNDER 24 HRS MONTHS DAYS HOURS MIN.		
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MARYLAND</b>		7b CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY</b> MD.					
10 CITY OR TOWN OF DEATH <b>BALTIMORE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>VETERANS ADMINISTRATION MEDICAL CENTER</b>				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Electrician</b>			12b KIND OF BUSINESS OR INDUSTRY <b>Koppers</b>		
13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE <b>MARYLAND</b>						13b COUNTY		13c CITY OR TOWN <b>BALTIMORE</b>		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14 FATHER'S NAME FIRST MIDDLE LAST <b>WILLIAM E. HOLMES</b>						15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>WINIFRED SWIFT</b>					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>YES</b>		16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>VW 2</b>		17 INFORMANT <b>217 16 6866</b>		ADDRESS <b>VAMC, Clinical Records Balto., Md. 21218</b>					
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hemorrhage 2° DIC</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>DIC</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Vasculitis; Renal Failure; Hypertension</b> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>Peritonitis</b>											
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (this hospital) attended the deceased from <b>DECEMBER 7, 1979</b> to <b>DECEMBER 22, 1979</b> , that (we) last saw the deceased alive on <b>DECEMBER 22, 1979</b> , and that in (our) opinion death occurred on the date and hour and from the causes stated above. (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>Elliott Friedman</b>						DEGREE <b>MD</b>			22c. DATE SIGNED <b>12/23/79</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Elliott Friedman</b>						22e. ADDRESS <b>3900 Loch Raven Blvd. Balto., Md. 21218</b>					
23a BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>12/27/1979</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Lorraine Pk.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Woodlawn Balto. Co. Md.</b>					
24 FUNERAL DIRECTOR NAME <b>G. Truman Schwab</b>				24b. ADDRESS <b>3512 Frederick Ave.</b>		25a. DATE REC'D. BY REGISTRAR <b>DEC 28 1979</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>			

MEDICAL CERTIFICATION

2

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP \_\_\_\_\_

DHMH - 16 50M 1/76  
(VR A 15 (4))

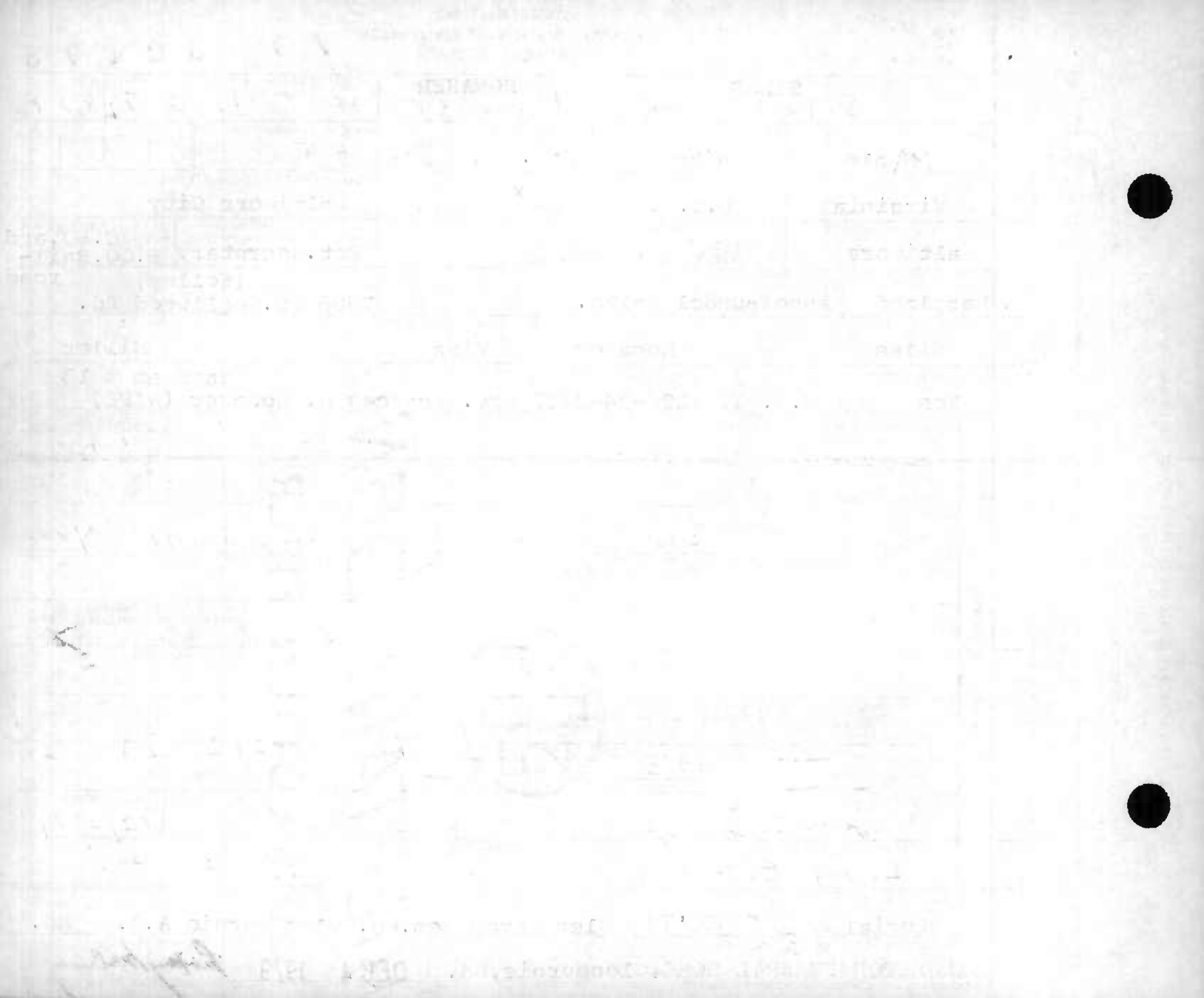
STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

79 30193

1. FOR STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT) FIRST <b>SILAS</b> MIDDLE <b>nmn</b> LAST <b>HONAKER</b>		2a. DATE OF DEATH MONTH <b>12</b> DAY <b>2</b> YEAR <b>79</b>		2b. HOUR <b>8:20P</b> M	
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH <b>Jan.</b> DAY <b>9</b> YEAR <b>24</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>55</b> YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Virginia</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.	
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>MERCY HOSPITAL</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Ret. Secretary</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>C.&amp;O. and B.&amp;O. Rail-</b>	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Maryland</b> 13b. COUNTY <b>AnneArundel</b> 13c. CITY OR TOWN <b>Balto.</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS (Solley) <b>7006 Ft. Smallwood Rd.</b>		13f. ROAD <b>road</b>	
14. FATHER'S NAME FIRST <b>Silas</b> MIDDLE <b></b> LAST <b>Honaker</b>		15. MOTHER'S MAIDEN NAME FIRST <b>Visa</b> MIDDLE <b></b> LAST <b>Miller</b>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b> (IF YES, GIVE WAR OR DATES) <b>W.W. II</b>		16b. SOCIAL SECURITY NO. <b>226-24-2427</b>	
17. INFORMANT ADDRESS <b>Same as # 13</b>		17. INFORMANT <b>Mrs. Frances H. Honaker (WIFE)</b>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute myocardial infarction</b> <b>410-</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b></b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) <b>Atherosclerotic coronary artery disease</b> <b>Yes.</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 hr.</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>19 71</b> to <b>12/2</b> , 19 <b>79</b> , that (I) (we) last saw the deceased alive on <b>12/2</b> , 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>Louis E. Grenzer</b>		DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>12/2/79</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Louis E. Grenzer</b>		22e. ADDRESS <b>1101 N. Calver + St.</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>5 DEC 79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Glen Haven Mem.Pk.</b>		23d. LOCATION CITY OR TOWN <b>Glen Burnie A.A.</b> COUNTY <b>Md.</b> STATE <b>Md.</b>	
24. FUNERAL DIRECTOR NAME <b>J. Easter</b>		ADDRESS <b>Singleton Funeral Home, Glen Burnie, Md.</b>		25a. DATE REC'D. BY REGISTRAR <b>DEC 4 1979</b>		25b. REGISTRAR'S SIGNATURE <b>Richard McCreedy</b>	

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										
1. FOR STATE REGISTRAR		7 9 3 0 1 9 4 REG. NO.								
1. DECEASED NAME (TYPE OR PRINT) <b>THERESA STELLA HOOVER</b> <i>Theresa STELLA Hoover</i>					2a. DATE OF DEATH MONTH DAY YEAR <b>12/1/79</b>			2b. HOUR <b>8 20 P.M.</b>		
3. SEX <b>FEMALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>SEPT. 15 1944</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>35</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>BALTIMORE, MD.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY, MD.</b>				
10. CITY OR TOWN OF DEATH <b>BALTIMORE, MD.</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>BALTIMORE CITY HOSPITALS</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>HOUSE WORK</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>AT HOME</b>		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>MD.</b>					13b. COUNTY <b>P-----</b>		13c. CITY OR TOWN <b>BALTIMORE</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>ADAM B. ZIEMSKI</b>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>FRANCES H. KULESZA</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>218-42-8569</b>		17. INFORMANT ADDRESS <b>ADAM B. ZIEMSKI ; 713 S. BAYLIS ST. BALTO., 21224, MD.</b>						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiopulmonary arrest</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Malignant Melanoma</b> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from <b>12/1/79</b> to <b>12/1/79</b> , that (I) (we) last saw the deceased alive on <b>12/1/79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <b>D. Siegel M.D.</b>				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c. DATE SIGNED <b>12/1/79</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>D. SIEGEL</b>				22e. ADDRESS <b>4940 EASTERN AVE., BALTO., 21224, MD.</b>						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>12-5-79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>SACRED HEART CEM.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>7401 GERMAN HILL RD., BA. CO., MD.</b>				
24. FUNERAL DIRECTOR NAME <b>Charles S. Seiler &amp; Son, Inc.</b>				24b. RES. <b>901 S. CONKLING ST. BALTO., 21224, MD.</b>		25a. DATE REC'D. BY REGISTRAR <b>DEC 6 1979</b>		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>		

RECEIVED

U.S. DEPARTMENT OF JUSTICE  
FEDERAL BUREAU OF INVESTIGATION

( )  
RECEIVED  
FEDERAL BUREAU OF INVESTIGATION

DATE: 12 12 1964

TO: DIRECTOR, FBI  
FROM: SAC, NEW YORK  
SUBJECT: JAMES EARL RAY, AKA; ALLEGED ATTEMPT TO OBTAIN PASSPORT FOR TRIP TO AFRICA; RE: MURDER OF MARTIN LUTHER KING, JR.

RE: NEW YORK TELETYPE TO BUREAU, 12/10/64.  
RE: NEW YORK TELETYPE TO BUREAU, 12/10/64.

On 12/10/64, the New York Office received information from the New York State Department of Transportation that James Earl Ray had applied for a passport to travel to Africa. The information was obtained from a review of the passport application records maintained by the New York State Department of Transportation. The records reflect that Ray applied for a passport on 12/10/64, and that the application was pending as of 12/10/64. The New York Office is currently conducting an investigation into the matter, and is seeking to determine the identity of the person who provided the information to the New York State Department of Transportation.

Very truly yours,  
Special Agent in Charge



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										79 30195 REG. NO.							
1. FOR STATE REGISTRAR										2a. DATE OF DEATH				MONTH DAY YEAR		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)										HELEN = MORGAN				12 11 79		11:10 AM	
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS.			
F			W			11 23 74			65 YRS.			MONTHS DAYS		HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH								
SYRACUSE NY.			USA						BALTIMORE CITY MD.								
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY					
BALTIMORE			U OF MARYLAND HOSPITAL						Cosmetician			Drug Co.					
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)										13b. INSIDE CITY LIMITS?		13c. STREET ADDRESS					
13a. STATE										YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		6450 Tauler CT. BALTO COUNTY 21045					
14. FATHER'S NAME										15. MOTHER'S MAIDEN NAME							
14. FIRST MIDDLE LAST										15. FIRST MIDDLE LAST							
HENRY FRANSON										CIARA M. GOGAN							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)										16b. SOCIAL SECURITY NO.		17. INFORMANT					
no										326-10-3517		Michael Horgan Same as above					
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
IMMEDIATE CAUSE (a) <u>Respiratory Arrest - Shock lung</u>										84 hours							
1629 DUE TO, OR AS A CONSEQUENCE OF (b) <u>E. Coli Sepsis</u>										3 days.							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last										DUE TO, OR AS A CONSEQUENCE OF (c) <u>Chemotherapy (Etoposide) for CA of Sh. lung.</u>							
										2 weeks.							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																	
<u>Disseminated Intravascular Coagulation</u>																	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?								
NA			NA			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)											
NA			HOUR A.M. MONTH DAY YEAR			NA											
			P.M. NA 19														
21d. INJURY OCCURRED			21e. PLACE OF INJURY			21f. LOCATION											
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> NA			NA			NA											
22a. I certify that (I) (this hospital) attended the deceased from <u>Nov 12</u> , 19 <u>79</u> , to <u>Dec 11</u> , 19 <u>79</u> , that (I) (we) lost																	
saw the deceased alive on <u>December 11</u> , 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.																	
22b. SIGNATURE						DEGREE				22c. DATE SIGNED							
<u>Michael E. Klein M.D.</u>										12-11-79							
22d. PHYSICIAN'S NAME (TYPE OR PRINT)						22e. ADDRESS											
Michael E. Klein M.D.						UNIV. OF MD HOSP 22 S. GREENE BAL MD.											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION								
Burial			12/17/79			All Saints Cem.			CITY OR TOWN COUNTY STATE								
									Des Plaines, Cook, Ill.								
24. FUNERAL DIRECTOR						25a. DATE REC'D. BY REGISTRAR				25b. REGISTRAR'S SIGNATURE							
NAME Raymond C. Fink ADDRESS Glen Burnie, Md.						DEC 13 1979				<u>Wesley McBrady</u>							





DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

7 9 3 0 1 9 6

REG. NO.

FOR  
1- STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>AUSTIN S. HORMAN</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>12-18-79</b>		2b. HOUR <b>4P</b> M
3 SEX <b>Male</b>	4 RACE <b>White</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>Dec. 10, 1913</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>66</b> YRS. MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Frederick Md.</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>Balto. City</b> MD.	
10 CITY OR TOWN OF DEATH <b>Balto.</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>JOHN L. DEATON MEDICAL CENTER</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Delivery Clerk</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Express Co</b>
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Md.</b> 13b. COUNTY <b>Balto.</b>		13c. CITY OR TOWN <b>Balto.</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS <b>118 S. Collins Ave.</b>	
14 FATHER'S NAME FIRST MIDDLE LAST <b>Welsh N. Horman</b>			15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Edna Smith</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>no</b>		16b. SOCIAL SECURITY NO <b>715-03-2492</b>		17 INFORMANT ADDRESS <b>118 S. Collins Ave. Balto. Md. 21229</b> <b>Mrs. Caroline R. Horman</b>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>PULMONARY EMBOLISM</b> <b>438-</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>BEDRIDDEN STATE</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>CVA</b>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2 DAYS</b> <b>YEARS</b> <b>YEARS</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>RETINITIS PIGMENTOSA, NEUROSENSORY DEAFNESS</b>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>10-29</b> , 19 <b>77</b> , to <b>12-18</b> , 19 <b>79</b> , that (I) (we) last saw the deceased alive on <b>12-17</b> , 19 <b>79</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>Marc S. Posner MD</b>		DEGREE <b>MD</b>		22c. DATE SIGNED <b>12-18-79</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>MARC S. POSNER</b>		22e. ADDRESS <b>6806 BONNIE RIDGE DR # 71</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>Dec. 21, 1979</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Mountain View Cem.</b>	
23d. LOCATION CITY OR TOWN COUNTY STATE <b>Sykesville Md.</b>					
24 FUNERAL DIRECTOR NAME <b>G. Truman Schwab 5151 Balto. National Pike 21229</b>				25a. DATE REC'D. BY REGISTRAR <b>DEC 24 1979</b>	
				25b. REGISTRAR'S SIGNATURE <b>Dorothy McBrady</b>	

MEDICAL CERTIFICATION

TO HOSPITALS AND ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
1. FOR STATE REGISTRAR			7-9 30197				REG. NO.				
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR		
Mary M. HORNEY						DECEMBER 25, 1979			2P M		
3 SEX		4 RACE		5. DATE OF BIRTH MONTH DAY YEAR		6 AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR		7. IF UNDER 24 HRS	
Female		White		Dec. 25 1897		82 YRS		MONTHS DAYS		HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
Md.		U.S.A.				Baltimore City MD.					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY		
Baltimore			816 E. 35th Street			Housewife			Own Home		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)						13a. INSIDE CITY LIMITS?		13b. STREET ADDRESS			
13a. STATE 13b. COUNTY 13c. CITY OR TOWN						YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		816 E. 35th St.			
14. FATHER'S NAME FIRST MIDDLE LAST						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST					
William Y. Adams						Lillie M. Stoops					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)				16b. SOCIAL SECURITY NO		17. INFORMANT ADDRESS					
No				213 79 7476		William O. Horney, Jr. Balto., Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>acute myocardial infarction</i>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
410- DUE TO, OR AS A CONSEQUENCE OF (b) <i>coronary sclerosis</i>										6 yrs	
DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
			P.M. 19								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 6/14/54 to 12/15/79, that (I) (we) lost saw the deceased alive on 12/15/79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE						DEGREE			22c. DATE SIGNED		
<i>William F. Renner</i>									12/27/79		
22d. PHYSICIAN'S NAME (TYPE OR PRINT)						22e. ADDRESS					
Dr. William F. Renner, M.D.						3222 St. Paul Street Balto., Md.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION CITY OR TOWN COUNTY STATE			
Burial			12/28/79		Spring Hill Cem.			Easton, Talbot, Md.			
24. FUNERAL DIRECTOR NAME						25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE		
Henry W. Jenkins & Sons Co. 4905 York Road Balto., Md. 21212						DEC 27 1979			<i>Robert M. ...</i>		



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 30198	
1. FOR STATE REGISTRAR		2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH DAY YEAR 12 27 1979								2b. HOUR 5:46 a.m.	
1. DECEASED NAME (TYPE OR PRINT)		FIRST DENISE		MIDDLE (UNKNOWN 79-82)		LAST HORSEY					
3. SEX female		4. RACE black		5. DATE OF BIRTH MONTH DAY YEAR 10 28 58		6. AGE (IN YEARS LAST BIRTHDAY) 21 YRS.		IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		7c. DATE PRONOUNCED DEAD 12 27 19 79	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.					
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 219 S. Hilton Street				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE Maryland		13b. COUNTY		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 116 N. Culver St.			
14. FATHER'S NAME FIRST MIDDLE LAST ELMER F. HORSEY				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MILDRED WINMOND							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. UNKN.		17. INFORMANT MILDRED W. HORSEY		ADDRESS SAME AS ABOVE					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 9654 Gunshot wound to face DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (d).											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 5:44 12-27 1979		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) subject shot by assailant							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) porch		21f. LOCATION STREET CITY OR TOWN COUNTY STATE 219 S. Hilton Street Baltimore, Maryland							
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input checked="" type="checkbox"/> , Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE Margaret Anne Knell		TITLE (SPECIFY) Assistant				MEDICAL EXAMINER		DATE SIGNED 12/27/79			
EXAMINER'S NAME (TYPE OR PRINT) Margarita A. Korell, M.D.		ADDRESS 111 Penn Street									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12-31-79		23c. NAME OF CEMETERY OR CREMATORY CEDAR HILL CEM.		23d. LOCATION CITY OR TOWN ANNE ARUNDEL CO.		STATE MD.			
24. FUNERAL DIRECTOR NAME Wm. C. March F/H		ADDRESS 1101 E. North Ave.		25a. DATE REC'D. BY REGISTRAR DEC 31 1979		25b. REGISTRAR'S SIGNATURE [Signature]					

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING," IN PENCIL IN ITEM 1b. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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1. FOR STATE REGISTRAR		DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH				REG. NO. 30199	
1. DECEASED NAME (TYPE OR PRINT) <b>Clark E. Hospelhorn</b>				2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> 12 11 1979		2b. HOUR M	
3. SEX <b>Male</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>Nov 12 1943</b>	6. AGE (IN YEARS) LAST BIRTHDAY <b>36 YRS.</b>	IF UNDER 1 YR. MONTHS DAYS <b>36</b>	IF UNDER 24 HRS. HOURS MIN <b>36</b>	2c. DATE PRONOUNCED DEAD MONTH DAY YEAR <b>12 11 1979</b>	2d. HOUR A M <b>2:00</b>
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Washington D.C.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City, MD.</b>	
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>University Hospital (STU)</b>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Foreman = U.S. Coast Guard</b>		12b. KIND OF BUSINESS OR INDUSTRY
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
13a. STATE <b>Md.</b>		13b. COUNTY <b>A.A. Co.</b>		13c. CITY OR TOWN <b>Brooklyn</b>		13e. STREET ADDRESS <b>212 Meadow Rd.</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>James Hospelhorn</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Anna Lee Higgs</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>219 40 9435</b>		17. INFORMANT ADDRESS <b>Sharon Hospelhorn same as 13e</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Multiple visceral and skeletal injuries</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR <del>XX</del> MONTH DAY YEAR <b>11:15 P.M. 12 10 1979</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) <b>Driver of motorcycle/tractor trailer impact</b>			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <b>street</b>		21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b>1100 E. Patapsco Ave., Baltimore City, Md.</b>			
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .							
ACTUAL SIGNATURE <i>Virginia L. Dolan</i>		TITLE (SPECIFY) <b>Assistant</b>		MEDICAL EXAMINER		DATE SIGNED <b>12/11/79</b>	
EXAMINER'S NAME (TYPE OR PRINT) <b>Virginia L. Dolan, M.D.</b>		ADDRESS <b>111 Penn Street</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>12/14/79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Glen Haven Mem. Pk</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Glen Burnie A.A. Md.</b>	
24. FUNERAL DIRECTOR NAME ADDRESS <b>George J. Gonce 4001 Ritchie Hgwy Balto 21225</b>				25a. DATE REC'D. BY REGISTRAR <b>DEC 14 1979</b>		25b. REGISTRAR'S SIGNATURE <i>Henry McCreedy</i>	



No.	Name	Origin	Date	Remarks
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO. 7 9 3 0 2 0 0

1- FOR  
STATE  
REGISTRAR

1 DECEASED NAME (TYPE OR PRINT) <b>Cornelia R. Hott</b>			2a. DATE OF DEATH MONTH <b>12</b> - DAY <b>24</b> - YEAR <b>1979</b>			2b. HOUR <b>5:35P</b> M	
3. SEX <b>Female</b>		4 RACE <b>White</b>		5. DATE OF BIRTH MONTH <b>07</b> - DAY <b>01</b> - YEAR <b>06</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>73</b> YRS MONTHS DAYS	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>West Va.</b>		7b CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE, CITY</b> MD.	
10 CITY OR TOWN OF DEATH <b>BALTIMORE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN EACH FACILITY, GIVE STREET ADDRESS) <b>ST. AGNES HOSPITAL</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Factory Worker</b>	
12b. KIND OF BUSINESS OR INDUSTRY <b>Meat factory</b>							

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE <b>Maryland</b>			13b COUNTY <b>Baltimore</b>		13c CITY OR TOWN <b>Baltimore</b>		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS <b>2237 Ramsey St., 21223</b>	
14 FATHER'S NAME FIRST <b>Cornelous</b> MIDDLE <b>McLaughlin</b> LAST <b>McLaughlin</b>			15. MOTHER'S MAIDEN NAME FIRST <b>Laura</b> MIDDLE <b>Higgins</b> LAST <b>Higgins</b>							
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>			16b SOCIAL SECURITY NO. <b>216-12-5562</b>		17. INFORMANT ADDRESS <b>Balto., Md. 21228</b> <b>Mrs. Diane M. Clarkson, 28 Bishops Lane,</b>					

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Infarction</b> <b>410 -</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>ASHD + D.M.</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
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PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>Dec 4</b> 19 <b>79</b> , to <b>Dec 24</b> 19 <b>79</b> , that (I) (we) lost saw the deceased alive on <b>Dec 24</b> 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (We) (I) (did not) view the body after death.							
22b. SIGNATURE <b>EVA MYERS M.D.</b>				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>E. Myers M.D.</b>				22e. ADDRESS <b>900 S. Caton Ave., Balto. Md 21229</b>			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>12-28-79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Crest Lawn Gard. of Mem. Marriottsville, Howard, Md.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE	
24 FUNERAL DIRECTOR NAME <b>Hubbard Funeral Home Inc 4107 Wilkens Ave 21229</b>				25a. DATE REC'D. BY REGISTRAR <b>DEC 28 1979</b>		25b. REGISTRAR'S SIGNATURE <i>Rafay McCreedy</i>	

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REC. NO. 30201

1- STATE REGISTRAR		2a. DATE KNOWN OF DEATH		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		2c. DATE ESTIMATED		2d. HOUR	
FREEMAN T		12 27 1979		4:00	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS)	7. IF UNDER 1 YR.	8. IF UNDER 24 HRS.
male	black	1-26-20	59 YRS.		
9a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	9b. CITIZEN OF WHAT COUNTRY?	9c. MARRIED		9d. BALTIMORE CITY OR COUNTY OF DEATH	
S.C.	USA	NEVER MARRIED		Baltimore City	
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION	12a. USUAL OCCUPATION		12b. KIND OF BUSINESS	
Baltimore	Md. General Hospital	(TYPE OF WORK FOR MOST OF WORKING LIFE)		OR INDUSTRY	
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS	
Md.		Balto.	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	421 Robert St.	
14. FATHER'S NAME	15. MOTHER'S MAIDEN NAME	16a. WAS DECEASED EVER IN U.S. ARMED FORCES?			
George Houston	Hester	(YES, NO, OR UNKNOWN)			
16b. SOCIAL SECURITY NO.	17. INFORMANT	18. CAUSE OF DEATH			
237-14-8785	Elsie Bailey	same			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1 DEATH WAS CAUSED BY: Arteriosclerotic cardiovascular disease					
IMMEDIATE CAUSE (a) 4292					
DUE TO, OR AS A CONSEQUENCE OF					
(b)					
DUE TO, OR AS A CONSEQUENCE OF					
(c)					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY?	
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS	21b. TIME OF INJURY	21c. HOW INJURY OCCURRED		21d. INJURY OCCURRED	
UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH	HOUR A.M. MONTH DAY YEAR	(ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)		WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
	P.M. 19			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)	
				21f. LOCATION	
				CITY OR TOWN COUNTY STATE	
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .					
ACTUAL SIGNATURE		TITLE (SPECIFY)		DATE SIGNED	
Virginia L. Dolan MD		M.D. Assistant		12/27/79	
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS			
Virginia L. Dolan, M.D.		111 Penn Street			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION	COUNTY	STATE
Burial	12-31-79	Westview Mem. Pk/	Balto., Md.		
24. FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR		25b. RECEIVED BY	
NAME		DEC 31 1979		Bailey f.H. 1348 Calhoun St.	
Bailey f.H. 1348 Calhoun St.					

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DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 30202

1. FOR STATE REGISTRAR		2a. DATE KNOWN OF DEATH		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		2c. DATE OF DEATH		2d. HOUR	
BEULAH COLES HOWARD		12 19 79		12 35	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS)	7. IF UNDER 1 YR.	7. IF UNDER 24 HRS.
female	black	8 4 46	83		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED	8. NEVER MARRIED	9. BALTIMORE CITY OR COUNTY OF DEATH	
CHARLOTTESVILLE	U.S.A.			Baltimore City	
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY		
Baltimore	1621 W. Baltimore Street	Homemaker	at home		
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS	
MD		BALTIMORE	YES	1621 W. BALTIMORE ST	
14. FATHER'S NAME	15. MOTHER'S MAIDEN NAME				
CHARLES COLES	Louise				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS		
NO		Doris Johnson	6426 VINCENT LA APT 201		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1 DEATH WAS CAUSED BY: Arteriosclerotic cardiovascular disease					
IMMEDIATE CAUSE (a) 4292					
DUE TO, OR AS A CONSEQUENCE OF					
(b)					
DUE TO, OR AS A CONSEQUENCE OF					
(c)					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?	
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
		P.M. 19			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE		TITLE (SPECIFY)		DATE SIGNED	
Hormez R. Guard, M.D.		Assistant		12/19/79	
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS			
		111 Penn Street			
23a. BURIAL, CREMATION, REMOVAL (RECEIPT)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN COUNTY STATE		
Reynolds	12/20/79	Kennedy Plot	CHARLOTTESVILLE, VA		
24. FUNERAL DIRECTOR	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE			
Marshall & Shyne	DEC 20 1979	Rickey McCurdy			



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				7 9 3 0 2 0 3 REG. NO.			
1. FOR STATE REGISTRAR				2a. DATE OF DEATH MONTH DAY YEAR			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST FREDERICK (nmn) HUBERT				DECEMBER 1 1979 11:10A			
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 5 / 12 / 09		6. AGE (IN YEARS LAST BIRTHDAY) 70 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Delaware		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD	
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Church Home Corporation		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Repairman		12b. KIND OF BUSINESS OR INDUSTRY B.G. & E. Co.	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md.		13b. COUNTY Baltimore		13c. CITY OR TOWN Dundalk		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Gustav Hubert		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Johanna Walters		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			
16b. SOCIAL SECURITY NO. 212-03-9158		17. INFORMANT ADDRESS Emily M. Hubert, 7947 Wise Ave. Dundalk, Md. 21222					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CANCER CACHEXIA AND CARCINOMATOSIS 1541 DUE TO, OR AS A CONSEQUENCE OF (b) METASTATIC <del>BARIN</del> CARCINOMA OF RECTUM DUE TO, OR AS A CONSEQUENCE OF (c)							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) this hospital attended the deceased from <u>NOVEMBER 23, 1979</u> to <u>DECEMBER 1, 1979</u> , that (I) <u>we</u> last saw the deceased alive on <u>DECEMBER 1, 1979</u> , and that in (my) <u>our</u> opinion death occurred on the date and hour and from the causes stated above, (I) <u>we</u> (did) (did not) view the body after death.							
22b. SIGNATURE <u>L. Reed</u>				DEGREE		22c. DATE SIGNED 1 DECEMBER 1979	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) MADHRAJ GOVINDA RAO				22e. ADDRESS CHURCH HOSPITAL CORPORATION, 100 N. BROADWAY, BALTIMORE, MARYLAND 21231			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 12/3/79		23c. NAME OF CEMETERY OR CREMATORY Green Mount Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore City, Md.	
24. FUNERAL DIRECTOR NAME Duda-Ruck, Inc., Baltimore, Md. 21222				25a. DATE REC'D. BY REGISTRAR DEC 6 1979		25b. REGISTRAR'S SIGNATURE <u>R. J. Helms</u>	





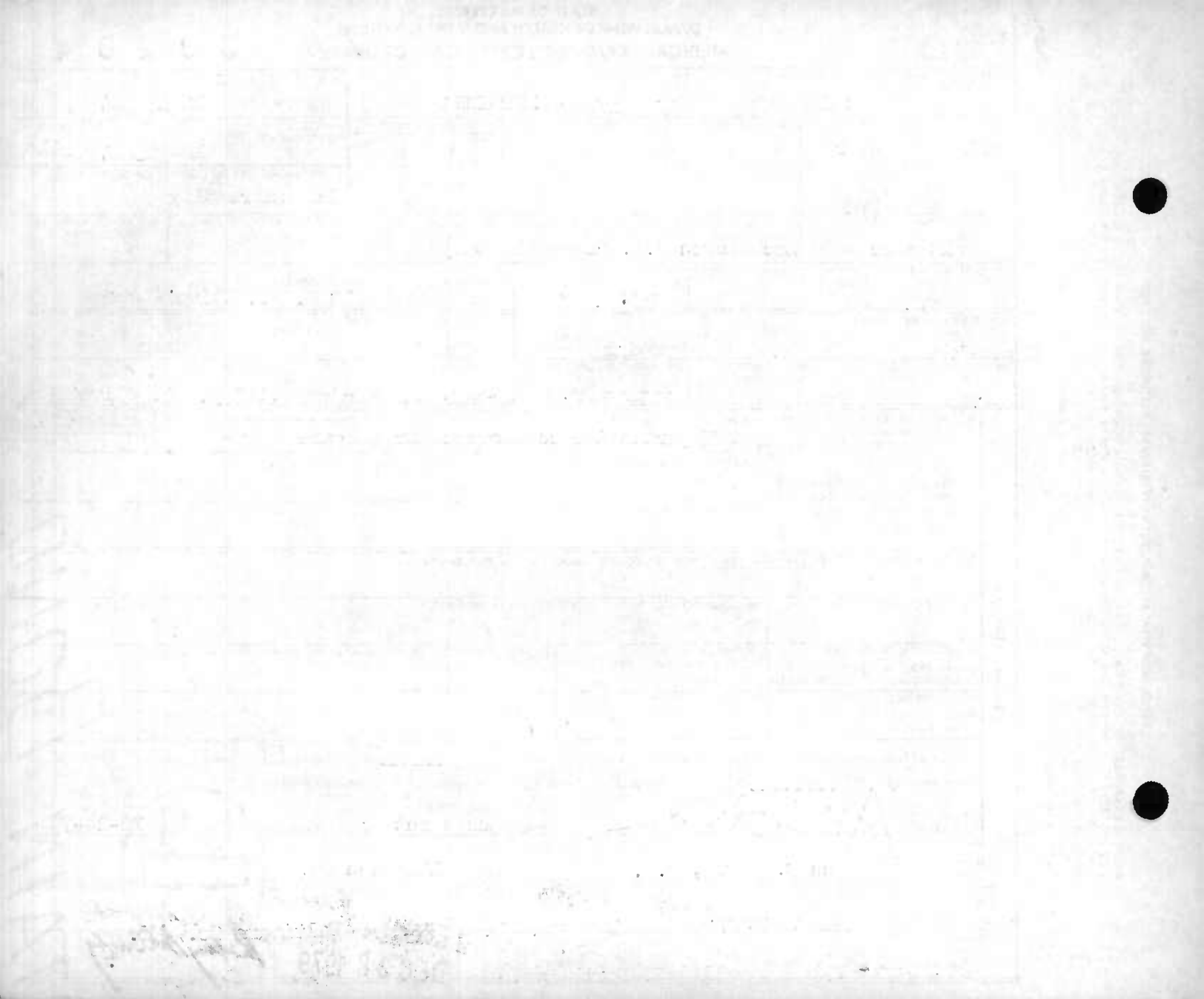
TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR OR PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 30204

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE KNOWN OF DEATH				2b. HOUR			
COSMO		D.		Huddins		(HUTGINS)		<input checked="" type="checkbox"/> MONTH <input type="checkbox"/> DAY <input type="checkbox"/> YEAR 12 23 1979				M			
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 1 YR.		IF UNDER 24 HRS.		2c. DATE PRONOUNCED DEAD				2d. HOUR	
male	negro	5 5 14		65 YRS.						12 23 1979				11pM	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED		NEVER MARRIED		9. BALTIMORE CITY OR COUNTY OF DEATH							
Md.		USA		WIDOWED		DIVORCED		Baltimore City				MD.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY									
Baltimore		Loch Raven V.A. Hospital (DOA)													
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS							
Md.				Balto.		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		112 N. Mt. Olivet Lane							
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES?		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS					
John		H. Huddins		Jennie Johnson		Yes		217-09-6009		Marie V. Huddins		112 N. Mt. Olivet La.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		PART I DEATH WAS CAUSED BY:		IMMEDIATE CAUSE (a)		Hypertensive cardiovascular disease		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
4029				DUE TO, OR AS A CONSEQUENCE OF											
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.				(b)		DUE TO, OR AS A CONSEQUENCE OF									
				(c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).															
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)											
		HOUR A.M. MONTH DAY YEAR													
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION		CITY OR TOWN		COUNTY		STATE					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .															
ACTUAL SIGNATURE		TITLE (SPECIFY)		DATE SIGNED		12-24-79									
Ann M. Dixon, M.D.		Assistant													
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS		111 Penn St.											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION		CITY OR TOWN		COUNTY		STATE			
Burial		12/28/79		King Mem. Pk.		Baltimore									
24. FUNERAL DIRECTOR		NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE							
Wm C March F/H		1101 E. North Ave.				DEC 28 1979									



TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

7 9 3 0 2 0 5  
REG. NO.

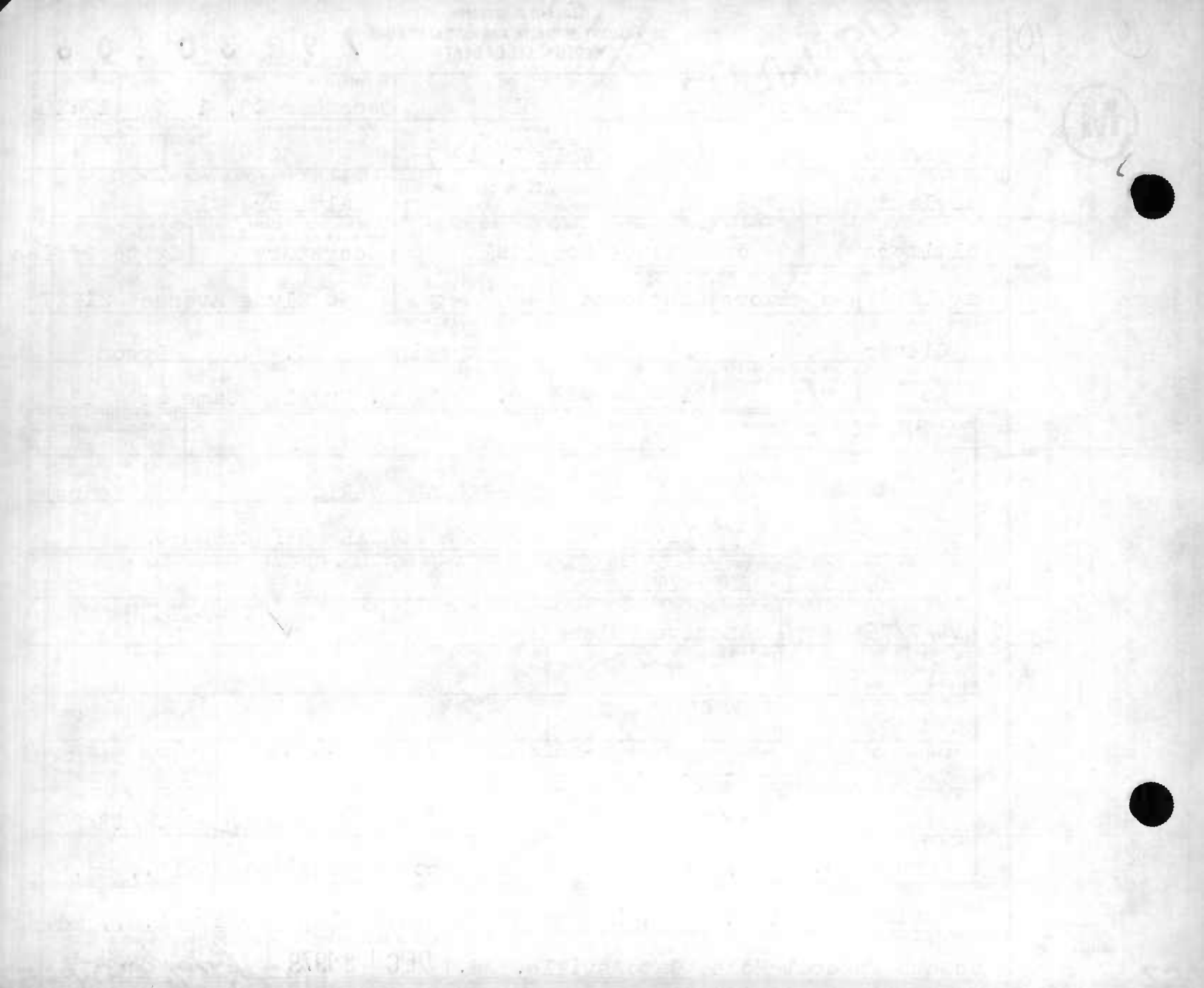
1. FOR STATE REGISTRAR		2a. DATE OF DEATH		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		2a. DATE OF DEATH		2b. HOUR	
HELEN		12. 23. 79		6:10 AM	
3. SEX		4. RACE		5. DATE OF BIRTH	
F		W		2/25/09	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. AGE (IN YEARS LAST BIRTHDAY)	
EUROPE		USA		71 YRS.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		9. BALTIMORE CITY OR COUNTY OF DEATH	
BALTO		CHURCH HOSP.		BALTO. CITY MD.	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		13a. STREET ADDRESS	
HSWE				733 S. POWELL ST	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	
NICK OLES		MARIA		NO	
17. INFORMANT		18. SOCIAL SECURITY NO.		19. ADDRESS	
GLORIA FREED		NONE		9314 CHERRY HILL COLLEGE PARK	
20. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))					
PART I. DEATH WAS CAUSED BY					
IMMEDIATE CAUSE (a) Cardiorespiratory Arrest					
DUE TO, OR AS A CONSEQUENCE OF					
(b) Intestinal Obstruction					
DUE TO, OR AS A CONSEQUENCE OF					
(c) Advanced Metastatic A Carcinoma of Stomach					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?	
Dec. 12, 1979		Intestinal Obstruction		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
		HOUR A.M. MONTH DAY YEAR			
		P.M. 19			
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION	
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				CITY OR TOWN COUNTY STATE	
22. I certify that (I) (this hospital) attended the deceased from Dec. 16, 19 79, to Dec. 23, 19 79, that (I) (we) lost saw the deceased alive on Dec. 23, 19 79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE		DEGREE		22c. DATE SIGNED	
M. L. Bijpuria				12. 23. 79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS		22f. DATE RECEIVED BY REGISTRAR	
M. L. Bijpuria M. D.		100 N. Broadway Balto. Md. 21231		DEC 28 1979	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY	
BURIAL		12/27/79		BALTO. NATL CEM	
24. FUNERAL DIRECTOR		24b. ADDRESS		24c. REGISTRAR'S SIGNATURE	
J. E. CONNELLY		300 MACE			



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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH7 9 3 0 2 0 6  
REG. NO.1- FOR  
STATE  
REGISTRAR

1 DECEASED NAME (TYPE OR PRINT) Irene Jane Hugel			2a. DATE OF DEATH MONTH DAY YEAR December 13, 1979			2b. HOUR PM 12:10				
3 SEX Female		4 RACE Caucasian		5 DATE OF BIRTH MONTH DAY YEAR July 7, 1947		6 AGE (IN YEARS LAST BIRTHDAY) 32 YRS.		7 UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.				
10 CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Bon Secours Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Secretary		12b. KIND OF BUSINESS OR INDUSTRY State Office		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)										
13a. STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN Lansdowne		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 256 Clyde Avenue 21227		
14 FATHER'S NAME FIRST MIDDLE LAST Oliver C. Picking					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Catherine C. Dyson					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) N/A		17. INFORMANT ADDRESS 218-46-9902 Mr. Frank D. Hugel Same as # 13						
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) HEPATIC FAILURE 5715 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost } DUE TO, OR AS A CONSEQUENCE OF (b) BLEEDING ESOPHAGEAL VARICES DUE TO, OR AS A CONSEQUENCE OF (c) LIVER CIRRHOSIS & PORTAL HYPERTENSION 6 Years								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) REGIONAL ENTERITIS										
19a. DATE OF OPERATION 12/7/79			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Massive Bleeding			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 12/5/1979 to 12/13/1979, that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on 12/13/1979, and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) did <input checked="" type="checkbox"/> (not) view the body after death.										
22b. SIGNATURE Hyung C. Kim, M.D.					DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 12/13/79			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Hyung C. Kim, M.D.					22e. ADDRESS Bon Secours Hospital Balt., Md.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 12/17/79		23c. NAME OF CEMETERY OR CREMATORY Glen Haven Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Glen Burnie A.A., Md.			
24 FUNERAL DIRECTOR NAME MacNabb Funeral Home					ADDRESS Catonsville, Md.		25a. DATE REC'D. BY REGISTRAR DEC 18 1979		25b. REGISTRAR'S SIGNATURE P. J. Brady	



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY, IT MUST BE EXECUTED WITHIN 72 HOURS. IF THE DEATH IS SUSPECTED TO BE A SUICIDE, THE CERTIFICATE SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PA-3. RETAIN PAGE 5 FOR FILES. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PA-3. RETAIN PAGE 5 FOR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITH PAGES 3 AND 4, IN THE DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 30207	
1. FOR STATE REGISTRAR											
1. DECEASED NAME (TYPE OR PRINT)		FIRST Elton		MIDDLE I		LAST Hughes		2a. DATE KNOWN OF DEATH		2b. HOUR	
								ESTIMATED <input checked="" type="checkbox"/> MONTH DAY 12 5 1979		YEAR 1979	
3. SEX male		4. RACE negro		5. DATE OF BIRTH MONTH DAY YEAR 12 23 1899		6. AGE (IN YEARS) LAST BIRTHDAY 80 YRS.		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City		2c. DATE PRONOUNCED DEAD 12 5 1979		2d. HOUR 1:18 a.m.	
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 633 N. Aisquith St.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) DRIVER		12b. KIND OF BUSINESS OR INDUSTRY TRUCK			
13a. STATE Md		13b. CITY OR TOWN BALTIMORE		13c. CITY OR TOWN BALTIMORE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 633 N. Aisquith Street			
14. FATHER'S NAME FIRST MIDDLE LAST Robert Hughes		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ella Hughes		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 213-14-4194		17. INFORMANT ADDRESS Carrie Brightful-Westminster			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease 4292 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE Hormez R. Guard, M.D.		TITLE (SPECIFY) M.D. Assistant		MEDICAL EXAMINER		DATE SIGNED 12-7-79					
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS 111 Penn St.									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12-9-79		23c. NAME OF CEMETERY OR CREMATORY Western Chapel		23d. LOCATION CITY OR TOWN COUNTY STATE Westminster Carroll Md					
24. FUNERAL DIRECTOR Robert E. Pruthi Jr.		ADDRESS Westminster, Md.		25a. DATE REC'D. BY REGISTRAR DEC 19 1979		25b. REGISTRAR'S SIGNATURE Anthony M. Cressy					

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
1. FOR STATE REGISTRAR		7 9 3 0 2 0 8 REG. NO.									
1. DECEASED NAME (TYPE OR PRINT)		FIRST HILTON		MIDDLE		LAST HUGHLETT		2a. DATE OF DEATH MONTH DAY YEAR 12 - 12 - 79		2b. HOUR 6 P M	
3 SEX Male		4 RACE Black		5 DATE OF BIRTH MONTH DAY YEAR Sept. 8, 1906		6 AGE (IN YEARS LAST BIRTHDAY) 73 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Va.		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Balt City MD.					
10 CITY OR TOWN OF DEATH Balt		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) D. Bledsoe				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired			12b. KIND OF BUSINESS OR INDUSTRY 0		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE Md.		13b. COUNTY		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 1449 North Carey 21217			
14 FATHER'S NAME FIRST MIDDLE LAST George Hughlett						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Julia Lampkins					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No				16b. SOCIAL SECURITY NO. 0		17. INFORMANT ADDRESS Inez Hughlett, 1449 N. Carey St. 21217					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a). 4275- Cardiorespiratory arrest DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on 12-10-79, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.											
22b. SIGNATURE Wayne H. Marley						DEGREE MD		22c. DATE SIGNED 12-10-79		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) W. Marley						22e. ADDRESS Balt City Hosp					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12/15/79		23c. NAME OF CEMETERY OR CREMATORY Baltimore, Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Maryland					
24. FUNERAL DIRECTOR NAME Kenneth D. Law						ADDRESS 4611 Park Heights		25a. DATE REC'D. BY REGISTRAR DEC 18 1979		25b. REGISTRAR'S SIGNATURE Lillian McCreedy	

Male

Black

Sept. 7, 1900

73

Va.

U.S.A.

www

Md.

George Hughlett

No-----0-----

Baltimore x

1449 North Carey St. 21217

Julia Lamkins

Inez Hughlett, 1449 N. Carey St. 21217

Retired -----0-----

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				7 9 3 0 2 0 9 REG. NO.			
1- FOR STATE REGISTRAR							
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Curtis W. Humphrey</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>12/8/79</b>		2b. HOUR <b>9:45 AM</b>	
3 SEX <b>Male</b>		4 RACE <b>Cauc.</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>9 18 22</b>		6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS HOURS MIN. <b>57 YRS.</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Tennessee</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore</b> MD	
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>South Baltimore General Hosp.</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Truck driver</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Service Station</b>	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE 13c. CITY OR TOWN <b>Md A.A. Severna Pk.</b>				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>327. Chestnut Hill Ave.</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>David Humphrey</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Mattie Scalp</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>Yes WWII</b>				16b. SOCIAL SECURITY NO. <b>410-34-4587</b>		17. INFORMANT ADDRESS <b>Thelma Humphrey same as above</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: <b>1519</b> IMMEDIATE CAUSE (a) <b>Respiratory &amp; Cardiac Arrest</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Metastatic poorly differentiated Adeno Carcinoma of stomach</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>of stomach</b>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>None</b>							
19a. DATE OF OPERATION <b>9/14/79</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>poorly differentiated adeno carcinoma of stomach</b>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>9/8</b> , 19 <b>79</b> , to <b>12/8</b> , 19 <b>79</b> , that (I) (we) last saw the deceased alive on <b>12/8</b> , 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>Mylene Jim Lim</b>				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>12-8-79</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Mylene Jim Lim</b>				22e. ADDRESS <b>South Baltimore General Hospital</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>12-11-79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cem.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore A.A. MD.</b>	
24. FUNERAL DIRECTOR NAME <b>Robert S. Barranco</b>				ADDRESS <b>501 R. Y. Chichester</b>		25a. DATE RECEIVED BY REGISTRAR <b>DEC 12 1979</b>	
				25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>			

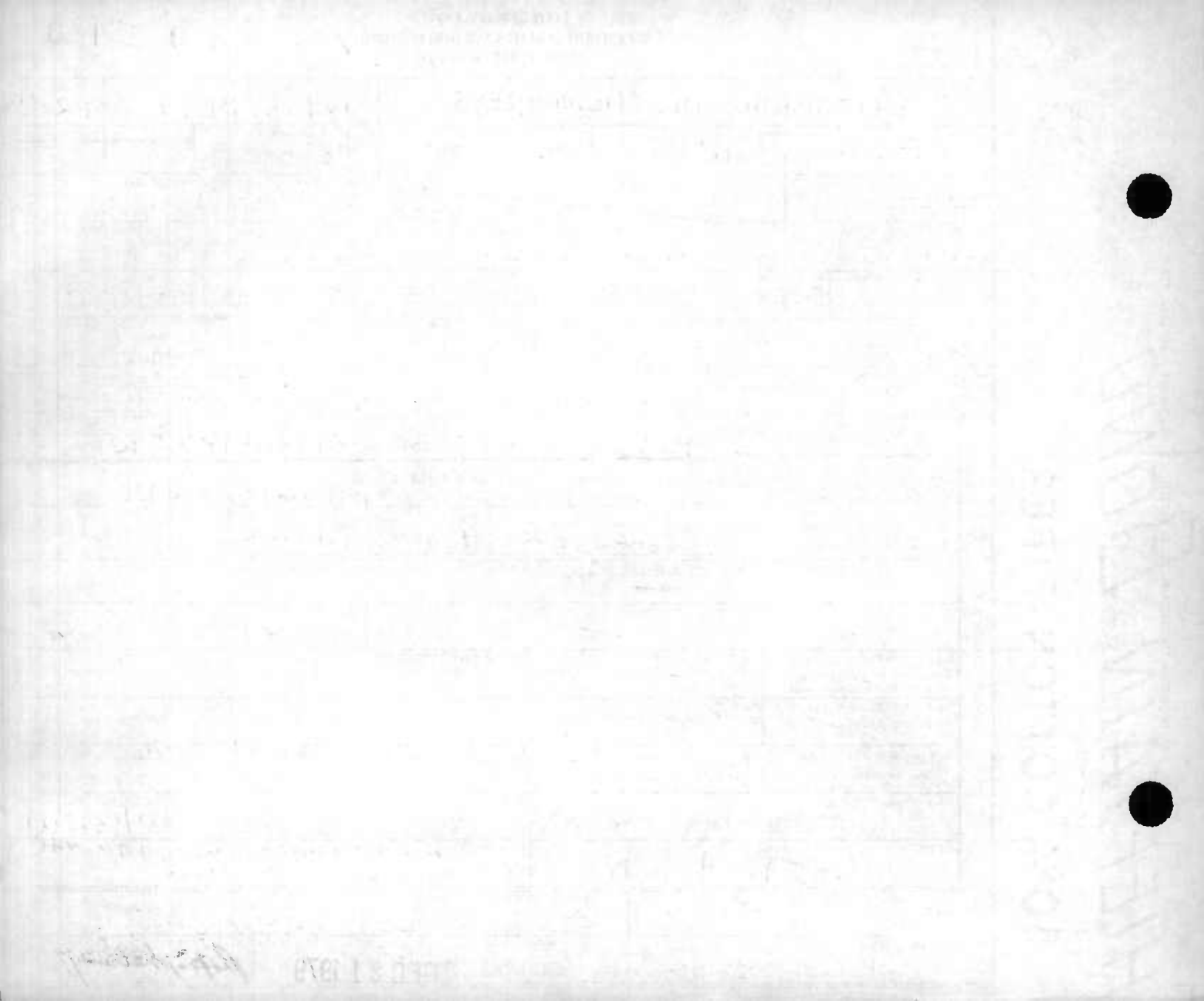


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										7 9 3 0 2 1 0			
1. FOR STATE REGISTRAR		REG. NO.											
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR
ELIZABETH. M. HUMPHREYS								12/18/1979					9-20 A.M.
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS			
Female		White		Nov. 28 1901		78		MONTHS		DAYS		HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH							
Maryland		USA				Baltimore City MD							
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)								12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Baltimore		North Charles General								Seamstress			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)													
13a. STATE		13b. CITY OR TOWN		13c. INSIDE CITY LIMITS?		13d. STREET ADDRESS							
Md		Baltimore		Dundalk		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		3468 McShane Way 21222					
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME									
FIRST MIDDLE LAST				FIRST MIDDLE LAST									
Joseph Zimmerman				Mary Snyder									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)				16b. SOCIAL SECURITY NO.		17. INFORMANT							
No				212-07-0735		Mrs. Mary M. Everett 3020 Bird View Rd. Westminister 21157							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) POSSIBLE CEREBRO-VASCULAR ACCIDENT. 4280 DUE TO, OR AS A CONSEQUENCE OF (b) CHRONIC OBSTRUCTIVE PULMONARY DISEASE Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. (c) CONGESTIVE HEART FAILURE													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
								YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 11/27/79, 1979, to 12/18/79, 1979, that (I) (we) last saw the deceased alive on 12/18/79, 1979, and that (I) (we) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.				22b. SIGNATURE D.R. Angelica MD				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 12/18/1979			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ANJARIA M.D.				22e. ADDRESS NORTH CHARLES GEN HOSPITAL BALTIMORE, MD. 21218									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE					
Burial				12/20/79		Most Holy Redeemer		Baltimore Maryland					
24. FUNERAL DIRECTOR NAME				25a. DATE REC'D. BY REGISTRAR				25b. REGISTRAR'S SIGNATURE					
Duda-Ruck Inc. 7922 Wise Ave. Dundalk, MD				21222				DEC 21 1979					



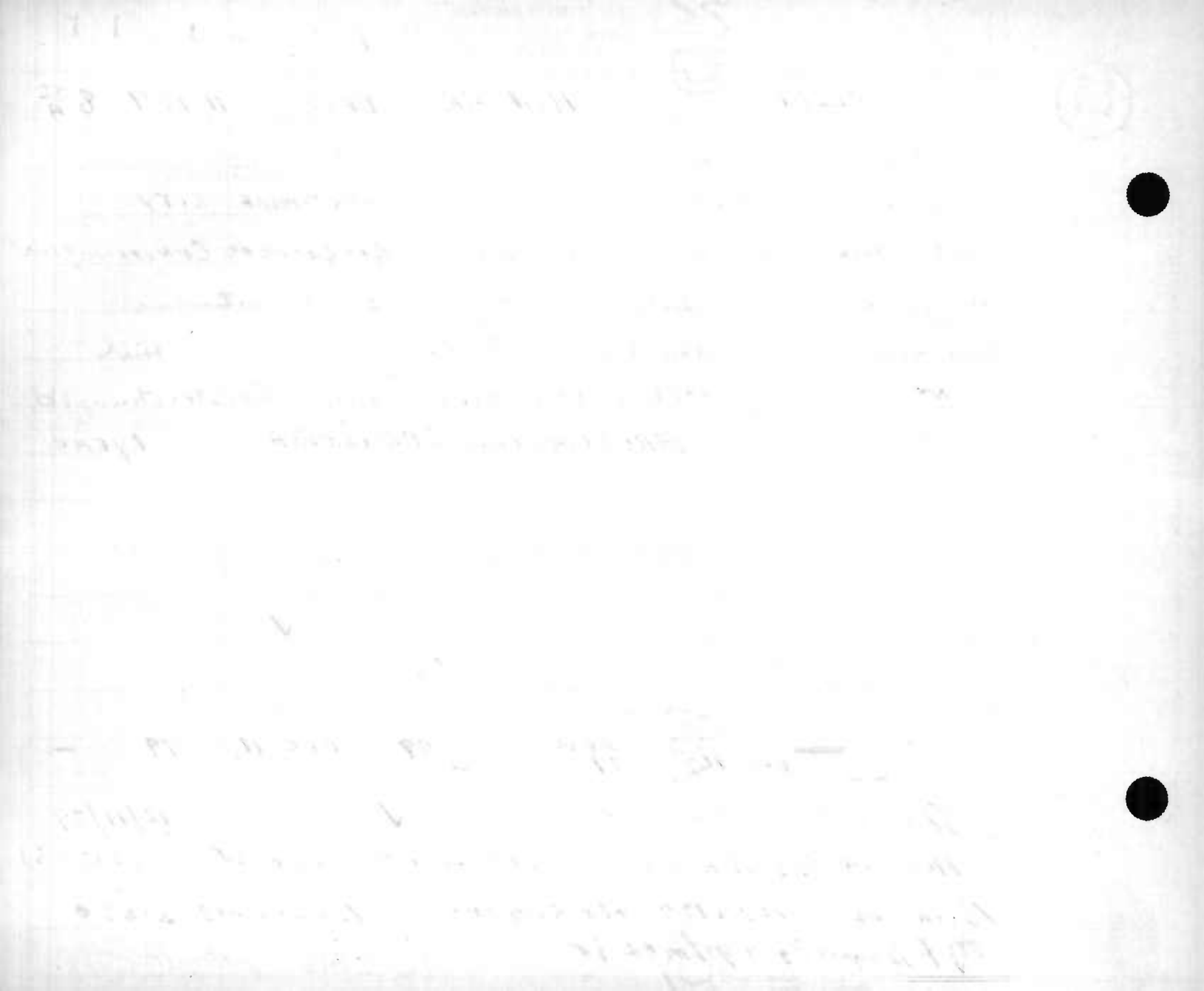


TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH																	
FOR 1 - STATE REGISTRAR			REG. NO. 7 9 3 0 2 1 1														
1. DECEASED NAME (TYPE OR PRINT)			FIRST CLYDE			MIDDLE HUNTER			LAST HUNTER			2a. DATE OF DEATH MONTH DAY YEAR DEC 11, 1979			2b. HOUR 8 50 A.M.		
3. SEX male			4. RACE Black			5. DATE OF BIRTH MONTH DAY YEAR 02 23 08			6. AGE (IN YEARS (LAST BIRTHDAY)) 71 YRS.			7. IF UNDER 1 YEAR MONTHS DAYS			8. IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) N. Carolina			7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.								
10. CITY OR TOWN OF DEATH Balt., Md.			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Baltimore Hospital						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Bor Lagoon Construction			12b. KIND OF BUSINESS OR INDUSTRY					
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland						13b. COUNTY Baltimore			13c. CITY OR TOWN Baltimore			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS 535 N. Fulton Ave.		
14. FATHER'S NAME FIRST MIDDLE LAST Anderson Hunter						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lula Hill											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no						16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 241-16-3827A			17. INFORMANT ADDRESS Jocelyn Johns Reisterstown, Md.								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 1629 BRONCHOGENIC CARCINOMA DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 YEAR					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) _____																	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE											
22a. I certify that (I) (the hospital) attended the deceased from FEB 19 79 to DEC 11, 19 79, that (I) (we) last saw the deceased alive on DEC 10, 19 79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																	
22b. SIGNATURE Howard H. Gendason MD.						DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>						22c. DATE SIGNED 12/11/79					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) HOWARD GENDASON MD.						22e. ADDRESS 2000 W. BALTIMORE ST. (21223)											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 12/15/79			23c. NAME OF CEMETERY OR CREMATORY Mt. Airy			23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore MD 21205								
24. FUNERAL DIRECTOR NAME J. H. Hargis 384 N. Gilman St.						25a. DATE REC'D. BY REGISTRAR DEC 12 1979			25b. REGISTRAR'S SIGNATURE Fitzroy Melroy								





## CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) <b>Edwin Taylor Hupfield</b>			2a. DATE OF DEATH 12 Month 17 Day 1979			2b. HOUR 11:30 AM				
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH <b>8/24/15</b>		6. AGE (In years last birthday) <b>64</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN		
7a. BIRTHPLACE (State or foreign country) <b>mo</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Baltimore city</b>				
10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Union Mem Hosp</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>MUSICIAN</b>			12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b>			13b. COUNTY <b>Carroll</b>		13c. CITY OR TOWN <b>Sykesville</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER <b>Springfield State Hosp</b>	
14. FATHER'S NAME First Middle Last <b>HENRY Hupfield</b>			15. MOTHER'S MAIDEN NAME First Middle Last <b>EDNA HOARD</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>			16b. SOCIAL SECURITY NO. <b>411-78-1478</b>		17. INFORMANT Address <b>Mrs MARGARET Hupfield 5507 RICHARD AVE BALTIMORE, MD</b>					
18. CAUSE OF DEATH (Enter only one cause per line) <b>496-1</b> PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Infarction</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Moderate to severe C.O.P.D.</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Schizophrenia, chronic</b> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
19a. DATE OF OPERATION <b>N/A</b>			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS CONTRIBUTING <input type="checkbox"/> UNDERLYING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from <b>4/6/79</b> , 19 <b>79</b> , to <b>12/14</b> , 19 <b>79</b> , that (I) (we) last saw the deceased alive on <b>12/14</b> , 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <b>Byung H. Song, MD</b>						22c. DATE SIGNED <b>12/17/79</b>				
22d. PHYSICIAN'S NAME (Type) <b>Byung H. Song</b>			22e. ADDRESS <b>Springfield Hosp. Center Sykesville MD</b>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			23b. DATE <b>12-18-79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Loudon Park</b>		23d. LOCATION (City or Town) (County) (State) <b>Baltimore, Maryland</b>			
24. FUNERAL DIRECTOR <b>Byung H. Song</b>						25a. REC'D BY REGISTRAR DATE <b>DEC 18 1979</b>		25b. REGISTRAR'S SIGNATURE <b>Robert McCreedy</b>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and any event, within 72 hours after death.



RECEIVED  
BUREAU OF PLANT INDUSTRY  
WASHINGTON, D. C.



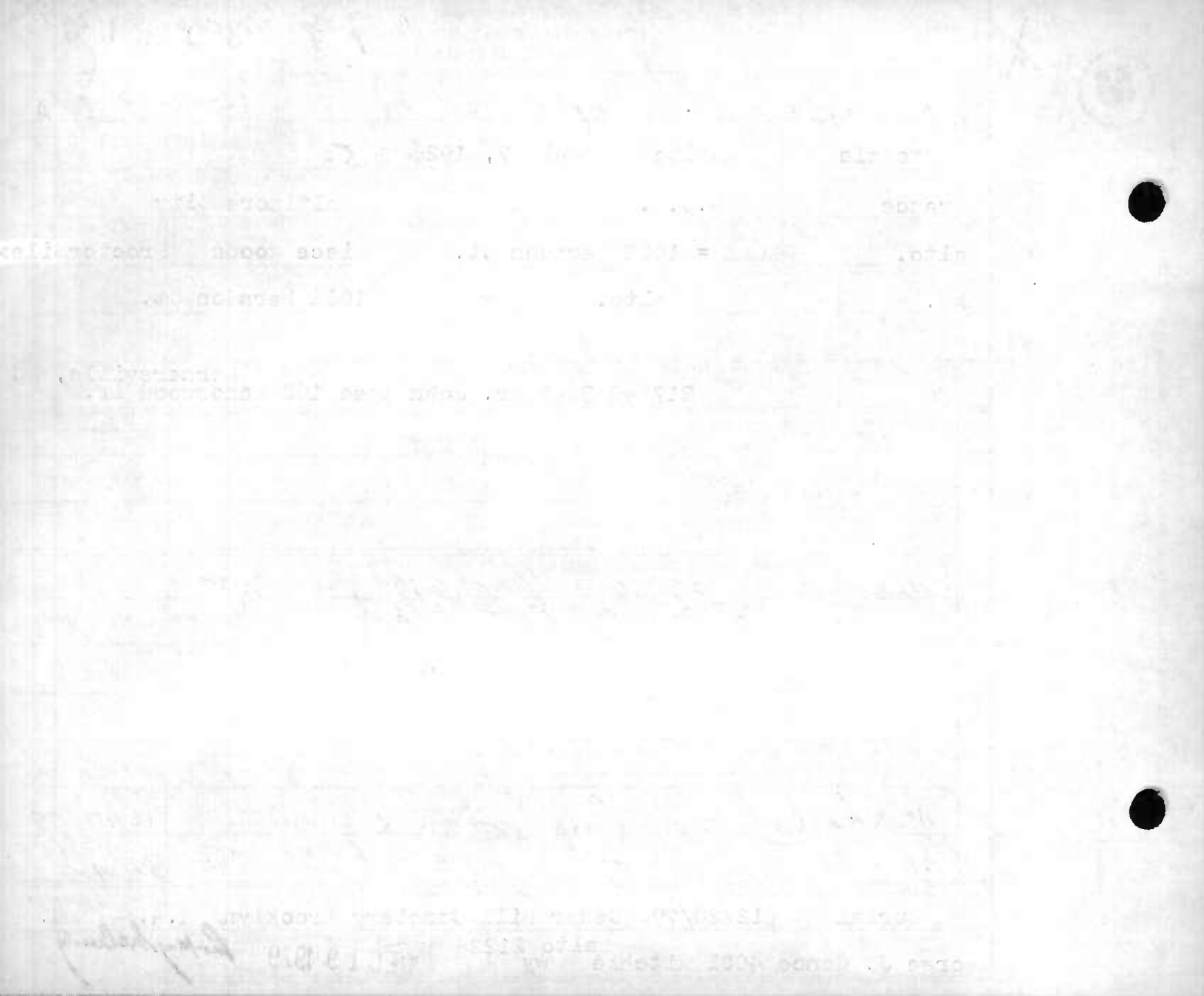
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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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FOR STATE REGISTRAR					DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					REG. NO.				
1 DECEASED NAME (TYPE OR PRINT) <b>ROLANDE R. LERIE</b>					2a DATE OF DEATH MONTH <b>12</b> DAY <b>17</b> YEAR <b>79</b>					2b HOUR <b>8:24</b> AM				
3 SEX <b>Female</b>		4 RACE <b>white</b>		5 DATE OF BIRTH MONTH <b>July</b> DAY <b>7</b> YEAR <b>1926</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>53</b> YRS		IF UNDER 1 YEAR MONTHS <b></b> DAYS <b></b>		IF UNDER 24 HRS HOURS <b></b> MIN <b></b>				
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>France</b>		7b CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.								
10 CITY OR TOWN OF DEATH <b>Balto.</b>		11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>HOME = 1002 Herndon Ct.</b>				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Piece goods</b>		12b KIND OF BUSINESS OR INDUSTRY <b>Procter</b>						
13a STATE <b>Md.</b>		13b COUNTY <b>Balto.</b>		13c CITY OR TOWN <b>Balto.</b>		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS <b>1002 Herndon Ct.</b>						
14 FATHER'S NAME FIRST <b></b> MIDDLE <b></b> LAST <b></b>					15 MOTHER'S MAIDEN NAME FIRST <b></b> MIDDLE <b></b> LAST <b></b>									
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>					16b SOCIAL SECURITY NO <b>217 40 3663</b>		17 INFORMANT ADDRESS <b>Kernersville, NC</b> <b>Mr. John Agee 160 Manorwood Dr.</b>							
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIAC ARREST</b> <b>4275</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (b) <b></b> DUE TO, OR AS A CONSEQUENCE OF (c) <b></b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b></b>				
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>1-ADDISON'S DISEASE 2-BRONCHIAL ASTHMA</b>														
19a DATE OF OPERATION <b>N/A</b>		19b CONDITION FOR WHICH OPERATION WAS PERFORMED <b>By Ambulance No 90</b>				20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>						
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR <b></b> A.M. <b></b> MONTH <b></b> DAY <b></b> YEAR <b>19</b> P.M. <b></b>		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) <b>N/A</b>										
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET <b></b> CITY OR TOWN <b></b> COUNTY <b></b> STATE <b></b>										
22a I certify that (I) (this hospital) attended the deceased from <b>N/A</b> , 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.														
22b SIGNATURE <b>M. K. Hodarande</b>					DEGREE <b></b>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c DATE SIGNED <b>12/17/79</b>				
22d PHYSICIAN'S NAME (TYPE OR PRINT) <b>M. K. HODARANDE</b>					22e ADDRESS <b>1101 E PATAPSCO AVE BAL MD 21225</b>									
23a BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b DATE <b>12/20/79</b>		23c NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cemetery</b>			23d LOCATION CITY OR TOWN <b>Brooklyn</b> COUNTY <b>A.A.</b> STATE <b>Md.</b>							
24 FUNERAL DIRECTOR NAME <b>George J. Gonce</b> ADDRESS <b>Balto 21225</b>					25a DATE REC'D. BY REGISTRAR <b>DEC 19 1979</b>			25b SIGNATURE <b>[Signature]</b>						



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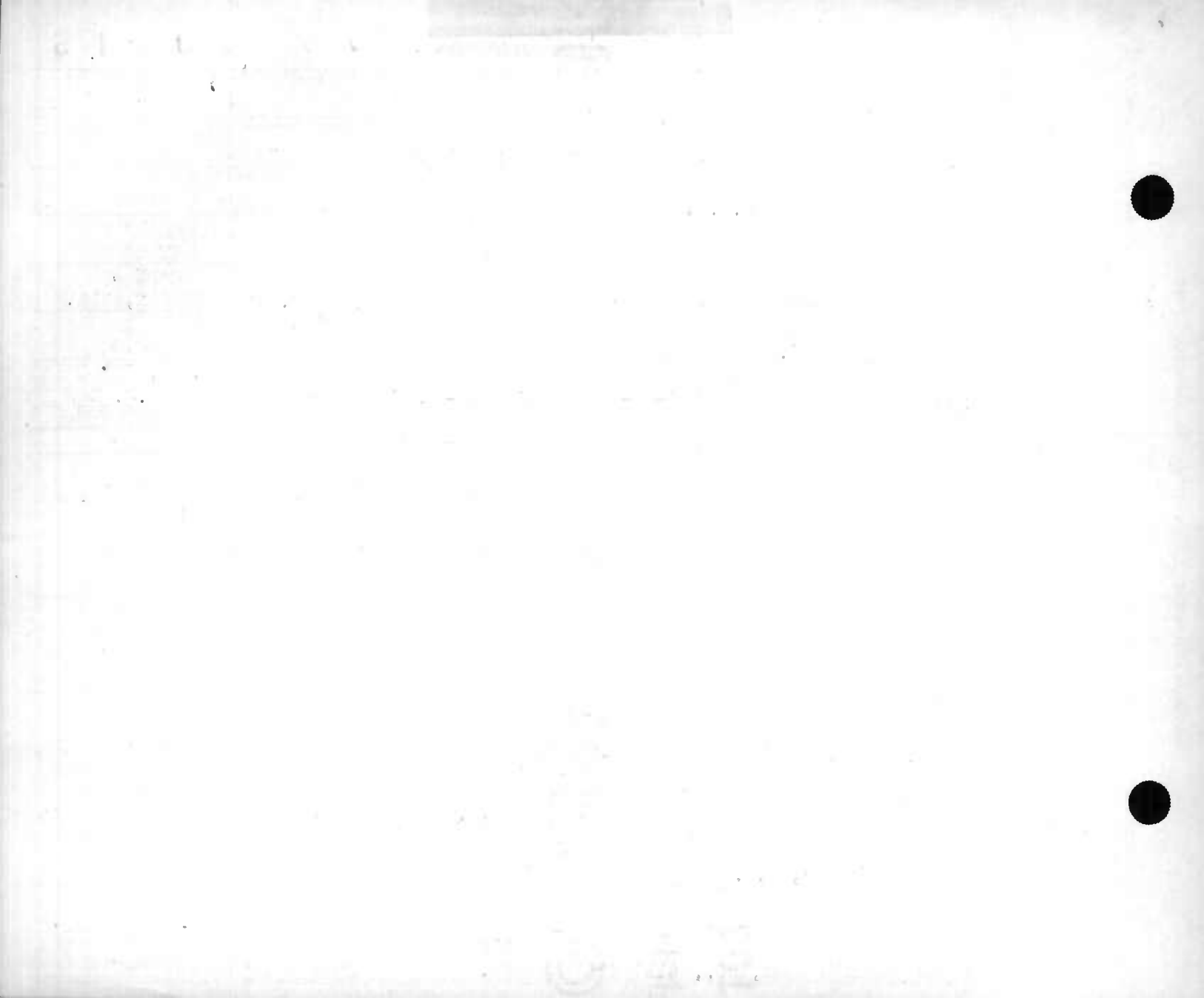
STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1- FOR STATE REGISTRAR									
1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Albert E. Ingelfinger</b>					2a DATE OF DEATH MONTH DAY YEAR <b>December 8, 1979</b>			2b HOUR <b>1:20p M</b>	
3 SEX <b>Male</b>		4 RACE <b>White</b>		5 DATE OF BIRTH MONTH DAY YEAR <b>8 21 10</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>69</b> YRS.		7 IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Germany</b>		7b CITIZEN OF WHAT COUNTRY? <b>USA</b>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.			
10 CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Maryland General Hospital</b>				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Upholster</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Self Employed</b>	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a STATE <b>Md</b>		13b COUNTY		13c CITY OR TOWN <b>Baltimore</b>		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS <b>815 Madison Avenue</b>	
14 FATHER'S NAME FIRST MIDDLE LAST <b>Franz Ingelfinger</b>					15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Mathilde Ingelfinger</b>				
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b>		16b SOCIAL SECURITY NO. <b>WW 2 215-18-9351</b>		17 INFORMANT <b>508 ADDRESS: 508 Resendale Street Mrs. Mathilde Hempf Baltimore, Md.</b>					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Brain Stem Stroke</b> <b>436-</b> DUE TO, OR AS A CONSEQUENCE OF (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost DUE TO, OR AS A CONSEQUENCE OF (c)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE					
22a I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>10/15/79</b> to <b>12/8/79</b> , that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on <b>12/8/79</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) did <input checked="" type="checkbox"/> view the body after death.									
22b SIGNATURE <b>Harvey Mishner</b>				DEGREE <b>MD</b>				22c DATE SIGNED <b>12-8-79</b>	
22d PHYSICIAN'S NAME (TYPE OR PRINT) <b>Harvey Mishner, M.D.</b>				22e ADDRESS <b>c/o 827 Linden Ave. Balto. MD 21201</b>					
23a BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b DATE <b>12/11/79</b>		23c NAME OF CEMETERY OR CREMATORY <b>Loudon Park Cemetery</b>		23d LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore Maryland</b>			
24 FUNERAL DIRECTOR NAME <b>Witzke Funeral Home of Catonsville</b>				25a DATE REC'D. BY REGISTRAR <b>DEC 13 1979</b>		25b REGISTRAR'S SIGNATURE <b>[Signature]</b>			
1630 Edmondson Avenue Catonsville, Md. 21228									



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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH7 9 3 0 2 1 5  
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST MARVIN ROY INGRAM			2a. DATE OF DEATH MONTH DAY YEAR 12 12 79		2b. HOUR 3:20 PM	
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR 01 22 1900		
6. AGE (IN YEARS LAST BIRTHDAY) 79 YRS.		7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) VIRGINIA		8. CITIZEN OF WHAT COUNTRY? U.S.A.		
9. BIRTHPLACE (STATE OR FOREIGN COUNTRY) VIRGINIA		10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) UNION MEMORIAL HOSPITAL		
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) MAINTENANCE		12b. KIND OF BUSINESS OR INDUSTRY STATE OF		12c. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MARYLAND		13b. CITY OR TOWN ---		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST EDWARD T. INGRAM		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST GERTRUDE GLENN PRICE		16. STREET ADDRESS 3103 ST. PAUL STREET, 21218		
17a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) unknown		17b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 216-09-8154		17c. INFORMANT ADDRESS SALUDA, VIRGINIA BRISTOW-FAULKNER FUNERAL HOME P.O. BOX 228		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Possible MYOCARDIAL INFARCTION</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Arteriosclerotic Heart Disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>410-</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from <u>11-29</u> , 19 <u>79</u> , to <u>11-30</u> , 19 <u>79</u> , that (I) (we) last saw the deceased alive on <u>11-29</u> , 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE <u>Donato Vargas Jr</u>		DEGREE M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 12/12/79		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DONATO VARGAS, M.D.		22e. ADDRESS 6010 YORK ROAD				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) REMOVAL/BURIAL		23b. DATE 12-15-79		23c. NAME OF CEMETERY OR CREMATORY CLARKSBURY CEMETERY		
24. FUNERAL DIRECTOR NAME HUBBARD FUNERAL HOME, INC.		24b. ADDRESS 21229 4107 WILKENS AVE.		25a. DATE REC'D. BY REGISTRAR 12/14/1979		
25b. REGISTRAR'S SIGNATURE <u>Patricia McCreedy</u>						





DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

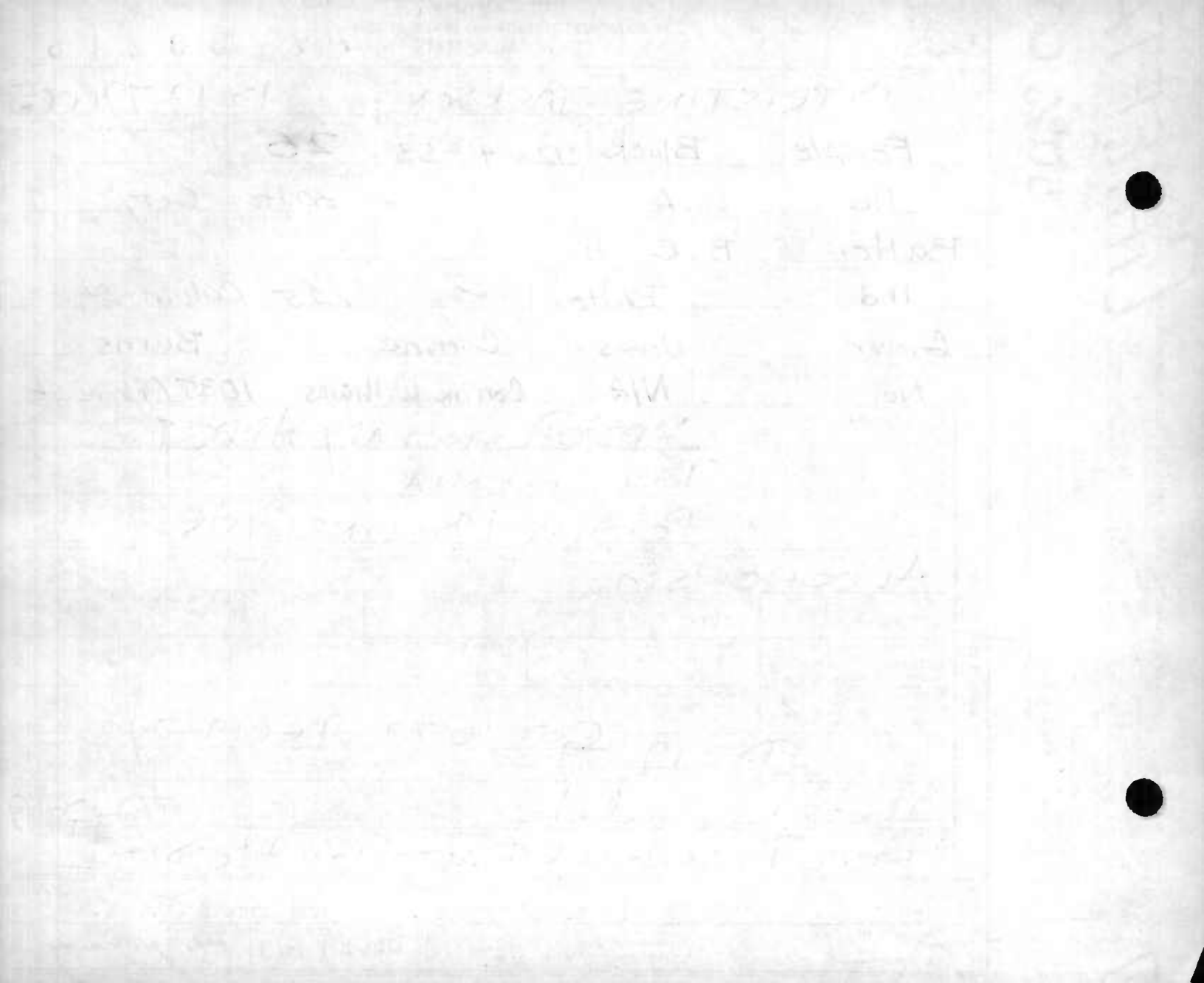
7 9 REG. NO. 3 0 2 1 6

1 - STATE REGISTRAR		1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>CHRISTINE JACKSON</b>		2a DATE OF DEATH MONTH DAY YEAR <b>12 19 79</b>		2b HOUR <b>0005</b>	
3 SEX <b>FEMALE</b>		4 RACE <b>Black</b>		5 DATE OF BIRTH MONTH DAY YEAR <b>12 4 53</b>		6 AGE (IN YEARS) (LAST BIRTHDAY) <b>26</b> YRS	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MD</b>		7b CITIZEN OF WHAT COUNTRY? <b>USA</b>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>Balto. City</b> MD.	
10 CITY OR TOWN OF DEATH <b>Balto.</b>		11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>B.C.H.</b>		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b KIND OF BUSINESS OR INDUSTRY	
13a STATE <b>md.</b>		13b COUNTY		13c CITY OR TOWN <b>Balto.</b>		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14 FATHER'S NAME FIRST MIDDLE LAST <b>Graver</b>		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Corrine Burns</b>		13e STREET ADDRESS <b>125 Colvin St.</b>			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b SOCIAL SECURITY NO. <b>N/A</b>		17 INFORMANT ADDRESS <b>Corrine Williams 1035 Orleans St.</b>			
18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIOPULMONARY ARREST</b> <b>1369</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>PNEUMONIA</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>PONTINE MYELINOLYSIS</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <b>ALCOHOLISM</b>							
19a DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>DEC 19 79</b> to <b>DEC 19 79</b> , that (I) (we) lost saw the deceased alive on <b>DEC 19 79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b SIGNATURE <b>Shoel Rosenthal</b>		DEGREE		22c. DATE SIGNED <b>12-12-19</b>			
22d PHYSICIAN'S NAME (TYPE OR PRINT) <b>Shoel Rosenthal</b>		22e ADDRESS <b>BALT CITY HOSPITAL</b>					
23a BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>12/21/79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Calvary Cem.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Anne Arundel Co., Md.</b>	
24 FUNERAL DIRECTOR NAME <b>Wm C March F/H</b>		ADDRESS <b>1101 E. North Ave.</b>		25a. DATE REC'D. BY REGISTRAR <b>DEC 21 1979</b>		25b. REGISTRAR'S SIGNATURE <b>Anthony McCreedy</b>	

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of one.

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

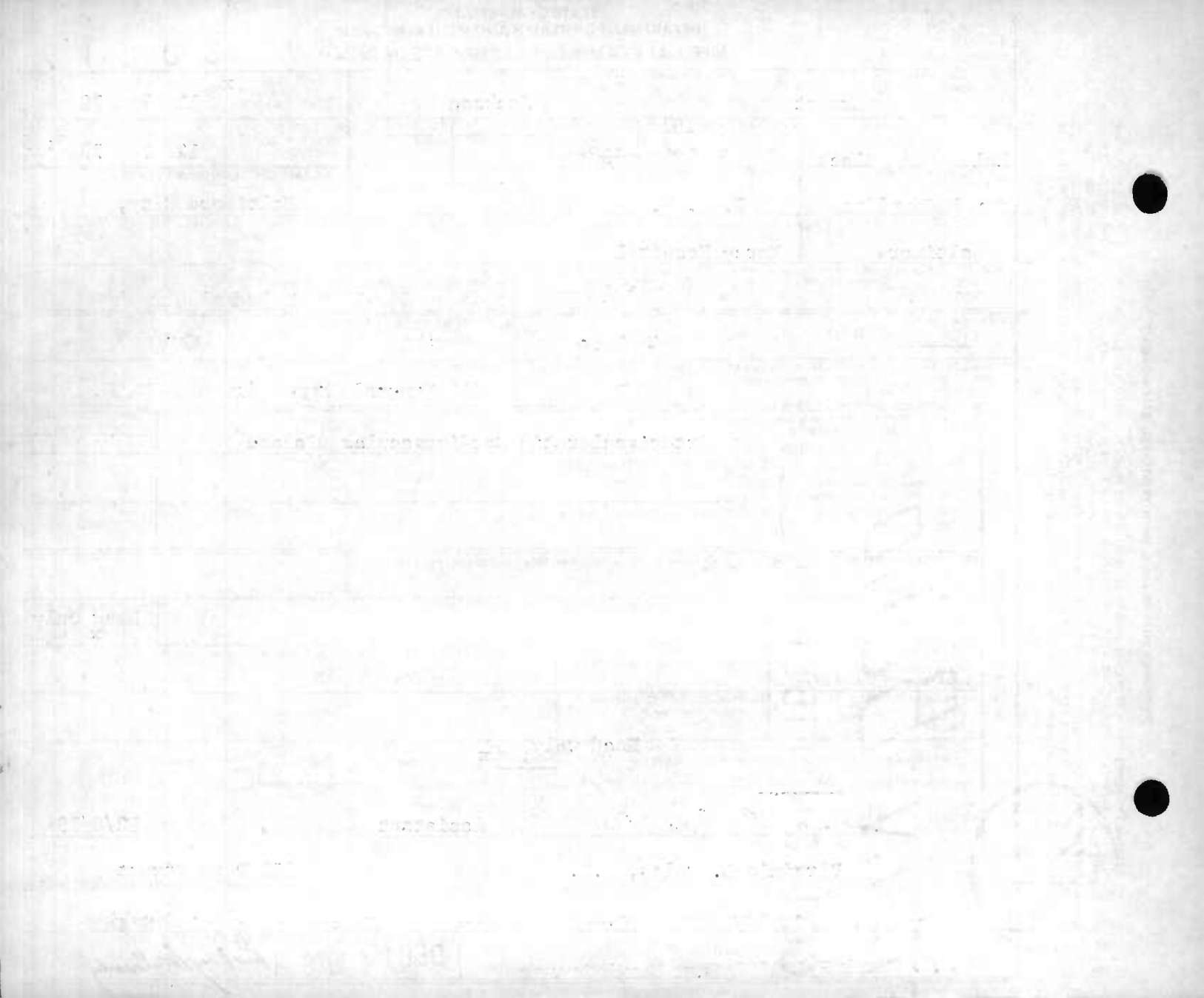
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

## MEDICAL CERTIFICATION

FOR 14 STATE REGISTRAR										DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 30217	
1. DECEASED NAME (TYPE OR PRINT) <b>Ernest Jackson</b>										2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR <b>12 7 19 79</b>										2b. HOUR M <b>5:45 P M</b>	
3. SEX <b>Male</b>		4. RACE <b>Black</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>5 4 1919</b>		6. AGE (IN YEARS LAST BIRTHDAY) YRS. <b>60</b>		IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		IF UNDER 24 HRS.		7c. DATE PRONOUNCED DEAD MONTH DAY YEAR <b>12 7 19 79</b>				2d. HOUR M <b>5:45 P M</b>					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>South Carolina</b>				7b. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City,</b> MD.									
10. CITY OR TOWN OF DEATH <b>Baltimore</b>				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Mercy Hospital</b>						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY							
13a. STATE <b>Maryland</b>										13b. COUNTY		13c. CITY OR TOWN <b>Baltimore</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>1027 Cathedral Street</b>					
14. FATHER'S NAME FIRST MIDDLE LAST <b>Lonzo Alonzo Jackson</b>										15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Martha Gragg</b>											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>No</b>				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>N/A</b>		17. INFORMANT ADDRESS <b>Hill Funeral Home Fairmont, N. C.</b>															
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic Cardiovascular Disease</b> <b>4292</b> Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____														APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).																					
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?														20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> <b>Head Only</b>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)													
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE													
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .																					
ACTUAL SIGNATURE <b>Virginia L. Dolan M.D.</b>										TITLE (SPECIFY) <b>Assistant</b> MEDICAL EXAMINER				DATE SIGNED <b>12/8/79</b>							
EXAMINER'S NAME (TYPE OR PRINT) <b>Virginia L. Dolan, M.D.</b>										ADDRESS <b>111 Penn Street</b>											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>				23b. DATE <b>12/16/1979</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Church Cemetery</b>				23d. LOCATION CITY OR TOWN COUNTY STATE <b>Fairmont, North Carolina</b>											
24. FUNERAL DIRECTOR NAME <b>Wm. C. March F/H 1101 East North Avenue</b>										25a. DATE REC'D. BY REGISTRAR <b>DEC 14 1979</b>				25b. REGISTRAR'S SIGNATURE <b>Anthony McCreedy</b>							



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHM-16 25M  
(VRA 15, 4) 1/79

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

7 9 3 0 2 1 8  
REG. NO.

1- FOR  
STATE  
REGISTRAR

1 DECEASED NAME (TYPE OR PRINT) <b>Florence Jackson</b>		2a DATE OF DEATH MONTH DAY YEAR <b>12-31-79</b>		2b HOUR <b>10:45 AM</b>	
3 SEX <b>Female</b>	4 RACE <b>Black</b>	5 DATE OF BIRTH MONTH DAY YEAR <b>01 07 1908</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>71</b> YRS.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>	7b CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD	
10 CITY OR TOWN OF DEATH <b>Baltimore</b>	11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>St. Agnes Hospital</b>		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Domestic</b>		12b KIND OF BUSINESS OR INDUSTRY <b>Pvt. Family</b>
13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE <b>Maryland</b>		13b COUNTY <b>Catonsville</b>	13c CITY OR TOWN <b>Catonsville</b>	13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14 FATHER'S NAME FIRST MIDDLE LAST <b>John W. Hammond</b>		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Mary E. Jones</b>			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, AND OF UNKNOWN) <b>NO</b>		16b SOCIAL SECURITY NO <b>219-32-3249</b>		17 INFORMANT ADDRESS <b>Mr. Charles Jackson 26 Winters Lane</b>	

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <b>Cardiopulmonary arrest</b> <b>410 -</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Suspect myocardial infarct</b> DUE TO, OR AS A CONSEQUENCE OF (c)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
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PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>Acute renal failure</b>			
19a DATE OF OPERATION <b>12/22/79</b>	19b CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Acute renal failure</b>	20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>	21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f LOCATION STREET CITY OR TOWN COUNTY STATE	
22a I certify that (I) (this hospital) attended the deceased from <b>12/22/79</b> to <b>12/31/79</b> that (I) (we) lost saw the deceased alive on <b>12/31/79</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			
22b SIGNATURE <b>KYAW NYUNT</b>	DEGREE	22c DATE SIGNED <b>12/31/79</b>	
22d PHYSICIAN'S NAME (TYPE OR PRINT) <b>KYAW NYUNT</b>	22e ADDRESS <b>ST. AGNES HOSPITAL 900 CATON AVENUE</b>		

23a BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>	23b DATE <b>01-05-1980</b>	23c NAME OF CEMETERY OR CREMATORY <b>Bushy Park Cem.</b>	23d LOCATION CITY OR TOWN COUNTY STATE <b>Cocksville Maryland</b>
24 FUNERAL DIRECTOR NAME ADDRESS <b>Herbert E. Nutter 3035 W. North Ave.</b>		25a DATE REC'D. BY REGISTRAR <b>JAN 8 1980</b>	25b REGISTRAR'S SIGNATURE <b>Henry McCready</b>



1953

ST. AGNES HOSPITAL AND CLINIC AVENUE

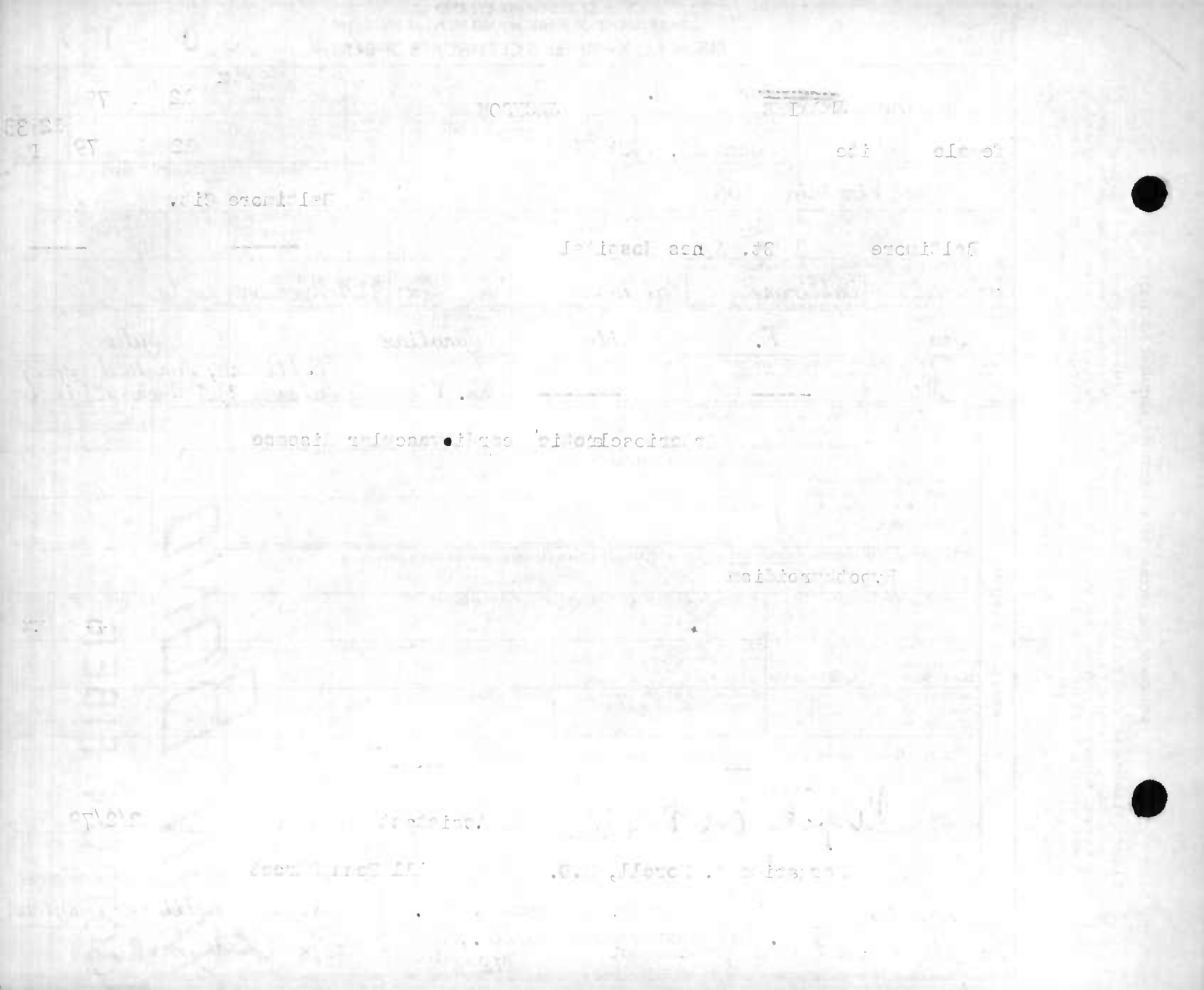
ST. AGNES HOSPITAL AND CLINIC AVENUE

ST. AGNES HOSPITAL AND CLINIC AVENUE

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR OFFICE. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 7 DAYS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP  
DHMH - 17  
(VR A15 ME (5))  
30M 7/73

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 30219	
1. FOR STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT) <u>Justine Jackson</u>						2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH <u>12</u> DAY <u>1</u> YEAR <u>1979</u>		2b. HOUR <u>M</u>	
3. SEX <u>female</u>		4. RACE <u>white</u>		5. DATE OF BIRTH MONTH <u>March</u> DAY <u>29</u> YEAR <u>1908</u>		6. AGE (IN YEARS) LAST BIRTHDAY <u>71</u> YRS.		IF UNDER 24 HRS. MONTHS <u>7</u> DAYS <u>19</u> HOURS <u>12</u> MIN <u>33</u>		2c. DATE PRONOUNCED DEAD MONTH <u>12</u> DAY <u>1</u> YEAR <u>1979</u>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>West Virginia</u>		7b. CITIZEN OF WHAT COUNTRY? <u>USA</u>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <u>Baltimore City</u> MD.					
10. CITY OR TOWN OF DEATH <u>Baltimore</u>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>St. Agnes Hospital</u>						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>-----</u>		12b. KIND OF BUSINESS OR INDUSTRY <u>-----</u>	
13a. STATE <u>Maryland</u>		13b. COUNTY <u>Baltimore</u>		13c. CITY OR TOWN <u>Baltimore</u>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <u>3321 Ryerson Circle</u>			
14. FATHER'S NAME FIRST <u>Ira</u> MIDDLE <u>F.</u> LAST <u>White</u>				15. MOTHER'S MAIDEN NAME FIRST <u>Caroline</u> MIDDLE <u>Eulim</u> LAST <u>Eulim</u>				16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <u>NO</u> (IF YES, GIVE WAR OR DATES) <u>-----</u>			
16a. SOCIAL SECURITY NO. <u>-----</u>				17. INFORMANT <u>Baltimore, Maryland</u> ADDRESS <u>21227</u>				17. INFORMANT <u>Mrs. Virginia Malenda</u> ADDRESS <u>3321 Ryerson Circle</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic cardiovascular disease</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>-----</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>-----</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). <u>Hypothyroidism</u>											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <u>19</u>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE <u>Margaret A. Korell</u>				TITLE (SPECIFY) <u>Assistant</u> MEDICAL EXAMINER				DATE SIGNED <u>12/2/79</u>			
EXAMINER'S NAME (TYPE OR PRINT) <u>Margarita A. Korell, M.D.</u>				ADDRESS <u>111 Penn Street</u>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Cremation</u>				23b. DATE <u>12/5/79</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Security Process, Inc.</u>		23d. LOCATION (CITY OR TOWN) <u>Catonsville</u> COUNTY <u>Baltimore</u> STATE <u>Maryland</u>			
24. FUNERAL DIRECTOR NAME <u>Mc Cully Funeral Home of Brooklyn</u>				24. FUNERAL DIRECTOR ADDRESS <u>237 E. Patapsco Avenue Balto., MD 21225</u>		DATE REC'D. BY REGISTRAR <u>DEC 5 1979</u>		REGISTRAR'S SIGNATURE <u>[Signature]</u>			





STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

7 9 3 0 2 2 0

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		2a. DATE OF DEATH		MONTH DAY YEAR		2b. HOUR	
Lillian Jackson				12-25-79		7:25P		M	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR	
Female		Black		09 21 1902		77		MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			
West Indies		U.S.A.				Baltimore City, MD.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
Baltimore		Provident Hospital		Beautician		Owner Shop			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS	
Maryland				Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		1033 W. Lanvale Street	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
		Henrietta Williams		NO		216-34-0135		Mr. Nanah H. Jacjson 1033 Lanvale St.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:		IMMEDIATE CAUSE (a)		DUE TO, OR AS A CONSEQUENCE OF		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
436-		MASSIVE Cerebrovascular Accident							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		(b)		DUE TO, OR AS A CONSEQUENCE OF		(c)			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
				YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
		P.M. 19							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from		NOV 9 19 79		to DEC 25 19 79		that (I) (we) last saw the deceased alive on		DEC 25 19 79	
						and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE		DEGREE		22c. DATE SIGNED					
Winston Hugh Williams MD		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		12/25/79					
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS							
Winston Hugh Williams MD		410 Provident Hospital Dept of Medicine							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE			
Burial		12-29-79		Arbutus Mem. Park		Balto Co. Maryland			
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Herbert E. Nutter 3035 W. North Ave.				JAN 2 1980		R. H. Nutter			

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It is to be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of the death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.



20% 01164

DRIVE IN





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 50M 1/76  
(VR A 15 (4))

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

7 9 3 0 2 2 1

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR
MARSHALL JACKSON					12	18	7F		12 PM
3. SEX	4. RACE	5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS
male	10 White	7. MONTH DAY YEAR 7 8 95			84 8 1977 YRS		MONTHS DAYS		HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH				
11111 Kentucky	U.S.				Baltimore City MD.				
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		
Baltimore Md	Sinai Hosp				Retired Farmer				
13a. STATE		13b. COUNTY		13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS		
Maryland				Baltimore	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		111 Lexington St		
14. FATHER'S NAME					15. MOTHER'S MAIDEN NAME				
FIRST MIDDLE LAST ? Jackson					FIRST MIDDLE LAST Unknown				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT ADDRESS					
Yes		WW 1		404-16-5380 Mr Howard Edelmann 6625 Hudson St					

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) Cardio-respiratory arrest		
4413 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last	DUE TO, OR AS A CONSEQUENCE OF (b) Ruptured Abdominal Aortic Aneurysm	
	DUE TO, OR AS A CONSEQUENCE OF (c)	

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 12/18, 19 79, to 12/18, 19 79, that (I) (we) last saw the deceased alive on 12/18, 19 79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE Adrian Barbul MD	DEGREE MD	ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>	22c. DATE SIGNED 12/18
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ADRIAN BARBUL		22e. ADDRESS SINAI HOSPITAL	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 12/21/79	23c. NAME OF CEMETERY OR CREMATORY Oak Lawn	23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Maryland
24. FUNERAL DIRECTOR NAME Leonard J Ruck Inc. Baltimore, Maryland		25a. DATE REC'D. BY REGISTRAR DEC 20 1979	25b. REGISTRAR'S SIGNATURE Ruthy McCreedy

0501 BP



Item 8 g539 1/16/80 g3

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

79 30222

FOR  
1- STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>William JACKSON</i>		2a. DATE OF DEATH MONTH DAY YEAR <i>12 31 79</i>		2b. HOUR <i>430 AM</i>	
3. SEX <i>Male</i>	4. RACE <i>negro</i>	5. DATE OF BIRTH MONTH DAY YEAR <i>3 1 1917</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>62</i>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>ALABAMA</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9a. BALTIMORE CITY OR COUNTY OF DEATH <i>Baltimore City</i>		9b. BALTIMORE CITY OR COUNTY OF DEATH <i>Baltimore City</i>			
10. CITY OR TOWN OF DEATH <i>Baltimore</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Provident Hosp</i>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Lab worker</i>	
12b. KIND OF BUSINESS OR INDUSTRY <i>Brick</i>		13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <i>MD</i> 13b. COUNTY <i>Baltimore</i> 13c. CITY OR TOWN <i>Baltimore</i>			
13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <i>2932 W. Myerson St</i>			
14. FATHER'S NAME FIRST MIDDLE LAST <i>Eliaz Jackson</i>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>May Eliazona Dennis</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>no</i>		16b. SOCIAL SECURITY NO. <i>218-09-0783</i>		16c. INFORMANT ADDRESS <i>Evon Dorothy Jackson</i>	
18. CAUSE OF DEATH (Enter only one cause per line or (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Septic</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Sup abscess of back</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Diabetes Mellitus, uncontrolled</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <i>Congestive heart failure, Renal insufficiency</i>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		19c. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		20c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21a. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21b. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21c. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <i>12-17</i> , 19 <i>79</i> , to <i>12-31</i> , 19 <i>79</i> , that (I) (we) last saw the deceased alive on <i>12-31</i> , 19 <i>79</i> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.					
22b. SIGNATURE <i>Patricia Jenkins</i>		DEGREE <i>MD</i>		22c. DATE SIGNED <i>12-31-79</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>PATRICIA JENKINS</i>		22e. ADDRESS <i>2600 LIBERTY HTS AVE PROVIDENT Hospital</i>			
23a. BURIAL, CREMATION, REMOVAL SPECIFY <i>Burial</i>		23b. DATE <i>1/6/80</i>		23c. NAME OF CEMETERY OR CREMATORY <i>1943 W. Myerson St</i>	
23d. LOCATION CITY OR TOWN COUNTY STATE <i>Baltimore MD</i>		24. FUNERAL DIRECTOR NAME ADDRESS <i>Mr. Hayes 638 N. Myerson St</i>		25a. DATE REC'D. BY REGISTRAR <i>JAN 2 1980</i>	
25b. REGISTRAR'S SIGNATURE <i>Patricia Jenkins</i>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



20% COTTON  
CHIFFON





BP  
DHMH - 17  
(VR A15 ME (5))  
30M 7/73

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY, EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL HOME. GIVE PAGE 4 TO THE MEDICAL EXAMINER. ALONG WITH FORM, PM 3, RETAIN PAGE 5 FOR YOUR RECORDS. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 30223	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST VIRGINIA Lee S. JACOBS										2a. DATE KNOWN OF DEATH ESTIMATED MONTH DAY YEAR 12 18 1979	2b. HOUR M P 1200
3. SEX female	4. RACE white	5. DATE OF BIRTH MONTH DAY YEAR 6/4/12	6. AGE (IN YEARS) (LAST BIRTHDAY) 67 YRS.	IF UNDER 1 YR. MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN	7c. DATE PRONOUNCED DEAD MONTH DAY YEAR 12 18 1979	2d. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.					
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) S.T.U. University Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Secretary		12b. KIND OF BUSINESS OR INDUSTRY Retired			
13a. STATE Maryland		13b. COUNTY Carroll		13c. CITY OR TOWN Westminster		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 4012 Arters Mill Road			
14. FATHER'S NAME FIRST MIDDLE LAST Joseph Theophilus Singewald of G				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Alberta Irene Reiter							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 216 32 1095		17. INFORMANT ADDRESS Richard J. Jacobs Balto., Md.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple injuries 8120 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 10:05 PM 12/18/1979		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) driver in auto/auto collision					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) roadway		21f. LOCATION STREET CITY OR TOWN COUNTY STATE Rt. 140 & Glen Falls Bds. Reisterstown Md. Balto. Co.					
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE H. R. Guard				TITLE (SPECIFY) M.D. Assistant				DATE SIGNED 12/19/79			
EXAMINER'S NAME (TYPE OR PRINT) Hormez R. Guard, M.D.				ADDRESS 111 Penn Street							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12/22/79		23c. NAME OF CEMETERY OR CREMATORY Loudon Park			23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Md.				
24. FUNERAL DIRECTOR NAME Henry W. Jenkins & Sons Co. 4905 York Road Balto., Md. 21212						25a. DATE REC'D. BY REGISTRAR DEC 20 1979		25b. REGISTRAR'S SIGNATURE D. H. H. H.			





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the death certificate with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a report filed.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

7 9 3 0 2 2 4

1. FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>Draga</b> (AKA <b>DRAGOTA</b> )		MIDDLE		LAST <b>JANKOV</b>		2a. DATE OF DEATH MONTH DAY YEAR <b>12/31/79</b>		2b. HOUR <b>9:50 PM</b>	
3 SEX <b>Female</b>		4 RACE <b>CAUCASIAN</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>11/6/87</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>82</b> YES		7. UNDER 24 HRS. MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Yugoslavia</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.			
10. CITY OR TOWN OF DEATH <b>Baltimore City</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>UNION MEMORIAL HOSPITAL</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Homemaker</b>		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE <b>Maryland</b>		13b. COUNTY <b>-</b>		13c. CITY OR TOWN <b>Baltimore</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>3035 Mayfield Ave.</b>	
14. FATHER'S NAME FIRST <b>-</b> MIDDLE <b>-</b> LAST <b>Georgivich</b>		15. MOTHER'S MAIDEN NAME FIRST <b>-</b> MIDDLE <b>-</b> LAST <b>Mohoslivich</b>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>217-14-0424</b>		17. INFORMANT ADDRESS <b>21014 Mike Liberatori, 1208 St. Francis Rd.</b>	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIOGENIC SHOCK</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DUE TO, OR AS A CONSEQUENCE OF (b) <b>MASSIVE INFERIOR MI</b>			
DUE TO, OR AS A CONSEQUENCE OF (c) <b>ASCVD</b>			

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>Susan Dumsa</b>		DEGREE <b>MD</b>		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Susan Dumsa</b>		22e. ADDRESS <b>UNION MEMORIAL HOSPITAL</b>					

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>1/4/80</b>		23c. NAME OF CEMETERY OR CREMATORY <b>St. Andrew Russ.Orth.Cem., Balto., Md.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore City Md.</b>	
24. FUNERAL HOME <b>St. Anne's Funeral Home, Inc.</b>		25a. DATE REC'D. BY REGISTRAR <b>JAN 3 1980</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>			

1960

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1960

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1- FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

9 30225

1. DECEASED NAME (TYPE OR PRINT) <b>Baby Girl Jenkins</b>			2a. DATE OF DEATH MONTH <b>12</b> DAY <b>10</b> YEAR <b>79</b>		2b. HOUR <b>6:00A</b>
3. SEX <b>Female</b>	4. RACE <b>Black</b>	5. DATE OF BIRTH MONTH <b>12</b> DAY <b>10</b> YEAR <b>79</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>✓</b> IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Md</b>	7b. CITIZEN OF WHAT COUNTRY? <b>✓</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.	
10. CITY OR TOWN OF DEATH <b>Baltimore</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Mercy Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Maryland</b> 13b. COUNTY <b>✓</b> 13c. CITY OR TOWN <b>Baltimore</b>			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS <b>2513 Linder Ave apt-19</b>	
14. FATHER'S NAME FIRST <b>MARSHALL</b> MIDDLE <b>✓</b> LAST <b>LEAZER</b>			15. MOTHER'S MAIDEN NAME FIRST <b>VERONICA</b> MIDDLE <b>✓</b> LAST <b>JENKINS</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS		

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) PART I. DEATH WAS CAUSED BY: <b>7798</b> IMMEDIATE CAUSE (a) <b>Cardio respiratory arrest</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>lung embolism</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>✓</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
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PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>Dec 10</b> , 19 <b>79</b> , to <b>Dec 10</b> , 19 <b>79</b> , that (I) (we) lost saw the deceased alive on <b>Dec 10</b> , 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE <b>V. M. P.</b>		DEGREE <b>MD</b>	22c. DATE SIGNED <b>12-10-79</b>
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>VIOLETA M. CARNELO, M.D.</b>		22e. ADDRESS <b>Mercy Hospital 301 N Paul Place Baltimore, Md 21202</b>	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Removal</b>	23b. DATE <b>12/13/79</b>	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN COUNTY STATE
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24. FUNERAL DIRECTOR NAME <b>Anatomy Board</b>	ADDRESS <b>Balto., Md.</b>	25a. DATE REC'D. BY REGISTRAR <b>DEC 17 1979</b>	25b. REGISTRAR'S SIGNATURE <b>Anthony A. Brady</b>
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed within 72 hours after death. Pages 3 and 4 should be filed within 72 hours after death. Pages 5 and 6 should be filed within 72 hours after death. Pages 7 and 8 should be filed within 72 hours after death. Pages 9 and 10 should be filed within 72 hours after death. Pages 11 and 12 should be filed within 72 hours after death. Pages 13 and 14 should be filed within 72 hours after death. Pages 15 and 16 should be filed within 72 hours after death. Pages 17 and 18 should be filed within 72 hours after death. Pages 19 and 20 should be filed within 72 hours after death. Pages 21 and 22 should be filed within 72 hours after death. Pages 23 and 24 should be filed within 72 hours after death. Pages 25 and 26 should be filed within 72 hours after death. Pages 27 and 28 should be filed within 72 hours after death. Pages 29 and 30 should be filed within 72 hours after death. Pages 31 and 32 should be filed within 72 hours after death. Pages 33 and 34 should be filed within 72 hours after death. Pages 35 and 36 should be filed within 72 hours after death. Pages 37 and 38 should be filed within 72 hours after death. Pages 39 and 40 should be filed within 72 hours after death. Pages 41 and 42 should be filed within 72 hours after death. Pages 43 and 44 should be filed within 72 hours after death. Pages 45 and 46 should be filed within 72 hours after death. Pages 47 and 48 should be filed within 72 hours after death. Pages 49 and 50 should be filed within 72 hours after death. Pages 51 and 52 should be filed within 72 hours after death. Pages 53 and 54 should be filed within 72 hours after death. Pages 55 and 56 should be filed within 72 hours after death. Pages 57 and 58 should be filed within 72 hours after death. Pages 59 and 60 should be filed within 72 hours after death. Pages 61 and 62 should be filed within 72 hours after death. Pages 63 and 64 should be filed within 72 hours after death. Pages 65 and 66 should be filed within 72 hours after death. Pages 67 and 68 should be filed within 72 hours after death. Pages 69 and 70 should be filed within 72 hours after death. Pages 71 and 72 should be filed within 72 hours after death. Pages 73 and 74 should be filed within 72 hours after death. Pages 75 and 76 should be filed within 72 hours after death. Pages 77 and 78 should be filed within 72 hours after death. Pages 79 and 80 should be filed within 72 hours after death. Pages 81 and 82 should be filed within 72 hours after death. Pages 83 and 84 should be filed within 72 hours after death. Pages 85 and 86 should be filed within 72 hours after death. Pages 87 and 88 should be filed within 72 hours after death. Pages 89 and 90 should be filed within 72 hours after death. Pages 91 and 92 should be filed within 72 hours after death. Pages 93 and 94 should be filed within 72 hours after death. Pages 95 and 96 should be filed within 72 hours after death. Pages 97 and 98 should be filed within 72 hours after death. Pages 99 and 100 should be filed within 72 hours after death.

BP



RECEIVED  
JAN 10 1964  
FBI  
NEW YORK

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. GIVE PAGE 4 TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR OFFICE. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 2 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP  
DHMM - 17  
(VR A15 ME (5))  
30M 7/73

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 3 0 2 2 6			
1. FOR STATE REGISTRAR										2a. DATE KNOWN OF DEATH		2b. DATE OF DEATH	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Elsie M. Jenkins										2a. DATE KNOWN OF DEATH 12 11 19 79		2b. DATE OF DEATH 12 11 19 79	
3. SEX Female		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR 12 3 32		6. AGE (IN YEARS LAST BIRTHDAY) 47 YRS.		7. IF UNDER 24 HRS. MONTHS DAYS HOURS MIN.		2c. DATE PRONOUNCED DEAD 12 11 19 79		2d. HOUR 3:55 A M	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland				7b. CITIZEN OF WHAT COUNTRY? U. S. A.				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City, MD.	
10. CITY OR TOWN OF DEATH Baltimore				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Lutheran Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Maryland				13b. COUNTY		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 3902 Fairfax Road			
14. FATHER'S NAME FIRST MIDDLE LAST John Ayers						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Gertrude Taylor							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)				16b. SOCIAL SECURITY NO. 215-28-3860		17. INFORMANT ADDRESS Lorraine C. Jones 2013 Druid Hill Avenue							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic cardiovascular disease with</u> <u>410 -</u> <u>XXXXXX</u> acute myocardial infarct Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .													
ACTUAL SIGNATURE <u>Virginia L. Dolan</u>				TITLE (SPECIFY) Assistant				DATE SIGNED 12/11/79					
EXAMINER'S NAME (TYPE OR PRINT) Virginia L. Dolan, M.D.				ADDRESS 111 Penn Street									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 12/15/1979		23c. NAME OF CEMETERY OR CREMATORY King Memorial Park				23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Co., Maryland			
24. FUNERAL DIRECTOR NAME ADDRESS Wm. C. March F/H 1101 East North Avenue						25a. DATE REC'D. BY REGISTRAR DEC 12 1979		25b. REGISTRAR'S SIGNATURE <u>Robert McCreedy</u>					

MEDICAL CERTIFICATION



File containing material from the Bureau of Plant Industry  
relating to the following: [illegible]

[illegible]

3

6

[illegible]

5

[illegible]

[illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

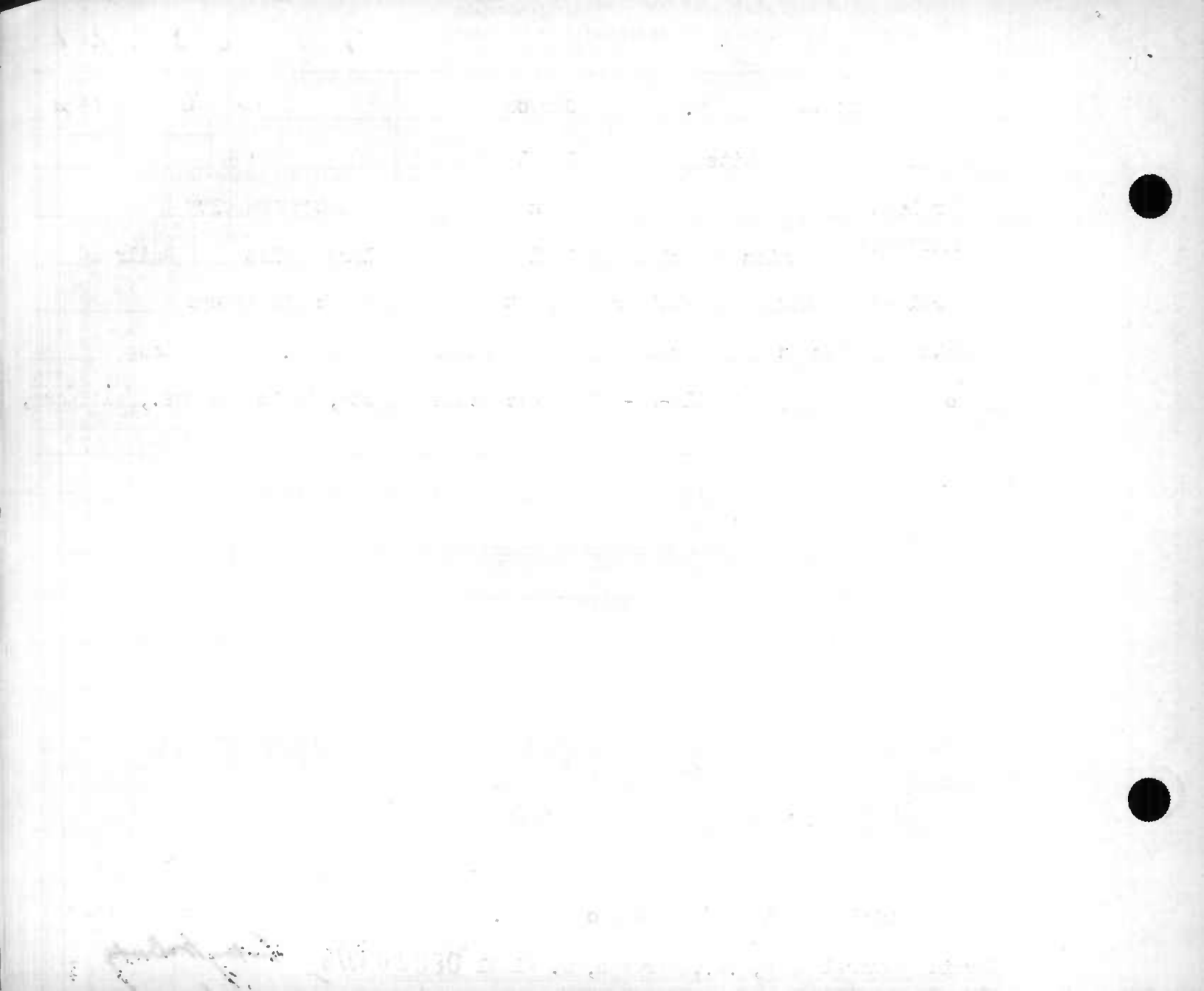
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

7 9 3 0 2 2 7

REG. NO.

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		2b. HOUR	
DECEASED NAME (TYPE OR PRINT) PEARL B. JESSOP		MONTH DAY YEAR 12 16 79		7 30 A M	
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR 1 1 1890		6. AGE (IN YEARS LAST BIRTHDAY) 89 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.	
10. CITY OR TOWN OF DEATH BALTIMORE	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Union Memorial Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Clerk Typist		12b. KIND OF BUSINESS OR INDUSTRY Railroad
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland		13b. CITY OR TOWN City	13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13d. STREET ADDRESS 828 McCabe Avenue	
14. FATHER'S NAME FIRST MIDDLE LAST John Warren Barnes		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Julia A. Long			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No	16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 212-07-8879	17. INFORMANT ADDRESS Md. 21212 Jacqueline Abbott, 828 McCabe Ave., Baltimore,			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhage 6191 DUE TO, OR AS A CONSEQUENCE OF (b) Recto-vaginal fistula DUE TO, OR AS A CONSEQUENCE OF (c)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 12/15/79
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 9/18 19 79, to 12/16 19 79, that (I) (we) lost saw the deceased alive on 12/16 19 79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE D. Berliner		DEGREE MD		22c. DATE SIGNED 12/16/79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) D. Berliner		22e. ADDRESS Union Memorial Hosp			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 12/21/79	23c. NAME OF CEMETERY OR CREMATORY Jessops Methodist		23d. LOCATION CITY OR TOWN COUNTY STATE Sparks Baltimore Maryland	
24. FUNERAL DIRECTOR NAME Tarring Funeral Home, P.A., Aberdeen, Md. 21001		25a. DATE REC'D. BY REGISTRAR DEC 20 1979		25b. REGISTRAR'S SIGNATURE R. J. [Signature]	





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of same.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR					REG. NO. 9 30228				
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Arden J. Johnson					2a. DATE OF DEATH MONTH DAY YEAR 12 10 79				
3. SEX MALE		4. RACE CAUCASIAN		5. DATE OF BIRTH MONTH DAY YEAR 03 26 06		6. AGE (IN YEARS LAST BIRTHDAY) 73 YRS.		7b. HOUR 4 P. M.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) West Virginia		7b. CITIZEN OF WHAT COUNTRY? U.S.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.			
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) South Balto General				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Maintenance		12b. KIND OF BUSINESS OR INDUSTRY Habison Walker	
13a. STATE MD		13b. COUNTY		13c. CITY OR TOWN BALTO		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 914 Freeman St.	
14. FATHER'S NAME FIRST MIDDLE LAST Lester Johnson					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARY KYLE				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) W.W. I		17. INFORMANT Mary A. Johnson		ADDRESS same as 13 e			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 4275 IMMEDIATE CAUSE (a) <u>Cardiorespiratory arrest.</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>antecedent hemorrhage.</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Rupture of Left ventricular myocardium</u>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <u>(D) Lower Lobe pneumonia</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 10-07 19 79, to 12-10 19 79, that (I) (we) last saw the deceased alive on 12-10 19 79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Miguel Fleischman					DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			22c. DATE SIGNED 12/10/79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Miguel Fleischman					22e. ADDRESS South Balto. General Hosp.				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12/13/79		23c. NAME OF CEMETERY OR CREMATORY Glen Haven Mem Pk		23d. LOCATION CITY OR TOWN COUNTY STATE Glen Burnie A.A. Md.			
24. FUNERAL DIRECTOR NAME George J. Gonce					ADDRESS Balto 21225 4001 Ritchie Hwy		25a. DATE REC'D. BY REGISTRAR DEC 14 1979		25b. REGISTRAR'S SIGNATURE Ruthy McCurdy

2505 BP

UNITED STATES DEPARTMENT OF JUSTICE  
FEDERAL BUREAU OF INVESTIGATION

100-100000

Report of I. J. [illegible]

Subject: [illegible]

x

Investigation conducted at [illegible]

on [illegible]

by [illegible]

and [illegible]

for [illegible]

the [illegible]

purpose of [illegible]

the [illegible]

and [illegible]

the [illegible]

and [illegible]

the [illegible]

and [illegible]

the [illegible]

and [illegible]

100-100000

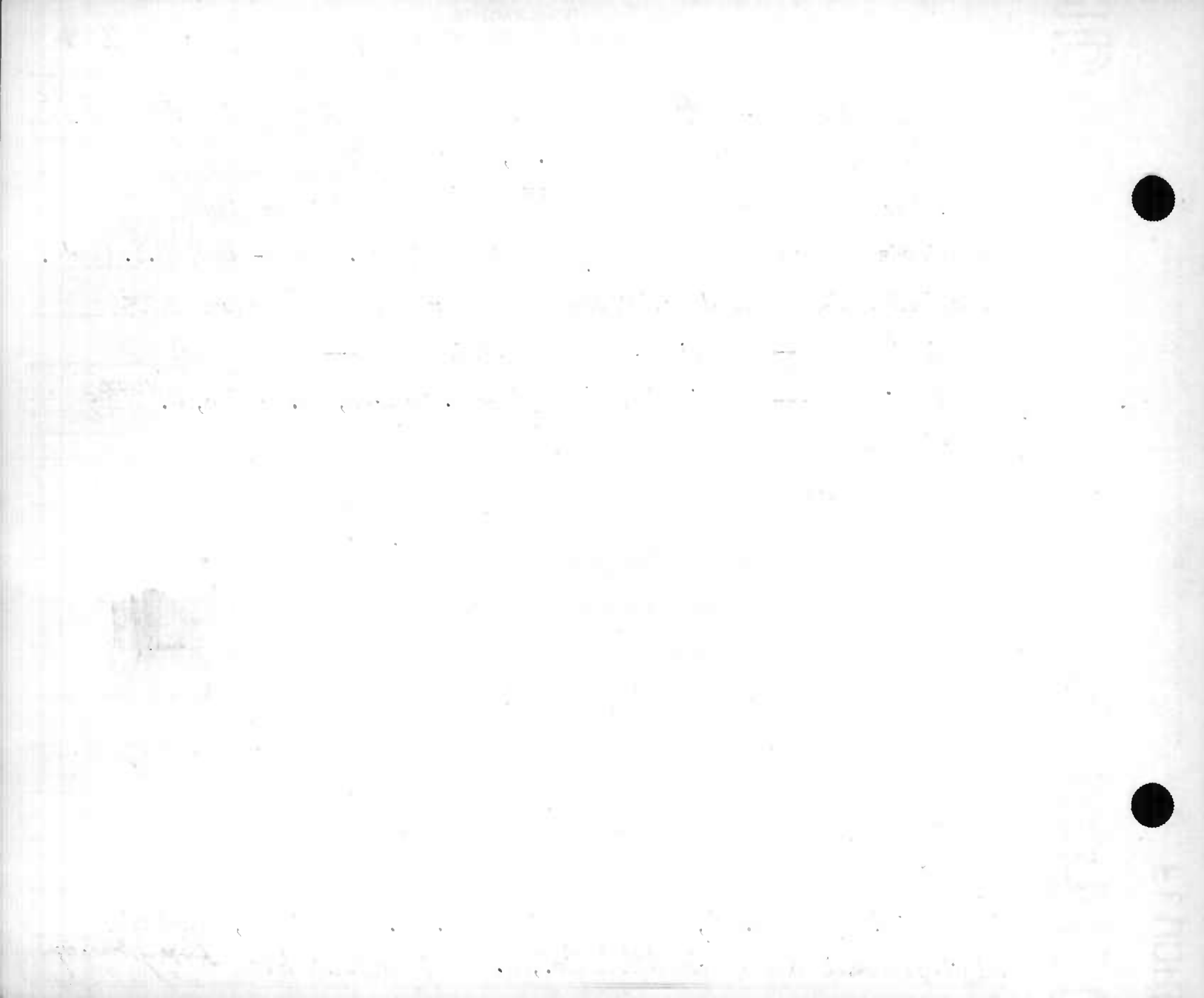
Report of I. J. [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR					REG. NO. 79 30229				
1. DECEASED NAME (TYPE OR PRINT) <i>Blanche Johnson</i>					2a. DATE OF DEATH MONTH DAY YEAR <i>12-21-79</i>			2b. HOUR <i>9:30</i> M	
3. SEX <i>Female</i>		4. RACE <i>White</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>Sept. 8, 1905</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>74</i> YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Maryland</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Baltimore City</i> MD.			
10. CITY OR TOWN OF DEATH <i>Baltimore</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>John L. Dayton Med. Ctr.</i>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Ret. Binder-Clerk</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>U.S. Gov't.</i>	
13a. STATE <i>Maryland</i>		13b. COUNTY <i>Anne Arundel</i>		13c. CITY OR TOWN <i>Baltimore</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <i>213 10th Avenue 21225</i>	
14. FATHER'S NAME FIRST MIDDLE LAST <i>William Liebold</i>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Mamie Graf</i>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i>		16b. SOCIAL SECURITY NO. <i>215 44 8558</i>		17. INFORMANT ADDRESS <i>213 10th Avenue Balto, Md. 21225</i>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>ARRHYTHMIA</i> <i>410-</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>MYOCARDIAL INFARCTION</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>BRAIN STEM STROKE</i>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>MINUTES</i> <i>3 MOS.</i>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <i>PROLONGED IMMOBILITY</i>									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>19</i>			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <i>9-25</i> 19 <i>79</i> , to <i>12-22</i> 19 <i>79</i> , that (I) (we) lost saw the deceased alive on <i>11-21</i> 19 <i>79</i> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>Marc S. Posner</i> DEGREE <i>M.D.</i>					ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED <i>12/22/79</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>MARC S. POSNER</i>					22e. ADDRESS <i>6806 BOWNE RIDGE DR #1</i>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>			23b. DATE <i>Dec. 24, 1979</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Meadowridge Mem. Pk.</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Baltimore, Maryland</i>		
24. FUNERAL DIRECTOR NAME <i>McGully Funeral Home of Brooklyn Balto., Md.</i>					25a. DATE REC'D. BY REGISTRAR <i>DEC 24 1979</i>		25b. REGISTRAR'S SIGNATURE <i>Robert McCready</i>		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 1B shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

7 9 3 0 2 3 0

1. DECEASED NAME (TYPE OR PRINT) <i>Christine Johnson</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>12 24 79</i>			2b. HOUR <i>6:30</i> P.M.	
3. SEX <i>F</i>	4. RACE <i>B</i>	5. DATE OF BIRTH MONTH DAY YEAR <i>10 28</i>	6. AGE (IN YEARS LAST BIRTHDAY) <i>51</i> YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>U.S.A.</i>	7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH <i>BALTIMORE</i> MD.				
10. CITY OR TOWN OF DEATH <i>BALTIMORE</i>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>SINAI HOSPITAL</i>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE <i>Maryland</i>			13b. COUNTY	13c. CITY OR TOWN <i>Baltimore</i>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST <i>OTHA JOHNSON</i>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>MARY STERLING</i>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i>		16b. SOCIAL SECURITY NO. <i>Unkn.</i>		17. INFORMANT ADDRESS <i>Calvin Johnson San Antonio, Tx. 6234 Charlottesville</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>cardiac failure.</i> 431- DUE TO, OR AS A CONSEQUENCE OF (b) <i>central hemorrhage</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c)							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING: <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <i>19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <i>12/24</i> , 19 <i>79</i> , to <i>12/24</i> , 19 <i>79</i> , that (I) (we) lost saw the deceased alive on <i>12/24</i> , 19 <i>79</i> , and that (I) (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>G. Cabaldoni</i> MD				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <i>12/24/79</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>CABALDONI</i>				22e. ADDRESS <i>SINAI HOSPITAL BALTIMORE MD</i>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>12-29-79</i>		23c. NAME OF CEMETERY OR CREMATORY <i>KING MEM. PK.</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>BALTIMORE CO. MD</i>	
24. FUNERAL DIRECTOR NAME <i>Wm. C. March F/H 1101 E. North Ave.</i>				25a. DATE REC'D. BY REGISTRAR <i>DEC 28 1979</i>		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>	

U.S. DEPARTMENT OF AGRICULTURE  
BUREAU OF PLANT INDUSTRY



Handwritten notes and signatures in the right margin, including a large signature that appears to be "J. H. ...".

Main body of the document containing faint, mostly illegible text and several handwritten signatures and initials. At the bottom left, there is a date stamp: "DEC 28 1919".

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		7 9 3 0 2 3 1		REG. NO.					
1. DECEASED NAME (TYPE OR PRINT) ELEANOR JOHNSON				2a. DATE OF DEATH MONTH DAY YEAR 12 20 79		2b. HOUR 3:45 A M			
3 SEX Female		4 RACE C/I		5. DATE OF BIRTH MONTH DAY YEAR 12-30-1897		6. AGE (IN YEARS LAST BIRTHDAY) 82 YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Balt. Md.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.			
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Providence Hosp.				12a. USUAL OCCUPATION (G LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE Maryland				13c. CITY OR TOWN Balt.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
14. FATHER'S NAME FIRST MIDDLE LAST Rev. Daniel Jones				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Elizabeth Dorsey					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 015-24-1997		17. INFORMANT ADDRESS Mrs. Marie Lewis 622 Baker St.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Congestive Heart Failure</u> 4140 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Arteriosclerotic Heart Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 days 1 year									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Renal insufficiency + Anemia</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>12/11</u> , 19 <u>79</u> , to <u>12/20</u> , 19 <u>79</u> , that (I) (we) last saw the deceased alive on <u>12/19</u> , 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>Roland T. Smoot M.D.</u>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 12/20/79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ROLAND T. SMOOT, M.D.				22e. ADDRESS 2300 GARRISON BLVD 21216					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 12-26-79		23c. NAME OF CEMETERY OR CREMATORY Mt. Zion Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Balt. Md.			
24. FUNERAL DIRECTOR NAME Joseph L. Burr				ADDRESS 2222 W. North Ave		25a. DATE REC'D. BY REGISTRAR DEC 21 1979		25b. REGISTRAR'S SIGNATURE <u>Rafael M. Brady</u>	



PLANT INDUSTRY

DEC 6 1938



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR 1 - STATE REGISTRAR		STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH		7 9 3 0 2 3 2 REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Frank Johnson.</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>12 14 79</b>		2b. HOUR <b>7:55 A</b> M
3. SEX <b>Male</b>	4. RACE <b>NEGRO</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>8 6 1919</b>		6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS HOURS MIN. <b>60</b> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN) <b>VIRGINIA</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City MD</b>	
10. CITY OR TOWN OF DEATH <b>Baltimore</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Provident Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE 13c. CITY OR TOWN <b>MARYLAND Baltimore</b>			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>2243 Brunst Street</b>
14. FATHER'S NAME FIRST MIDDLE LAST <b>Unkn.</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Unkn.</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>---</b>		17. INFORMANT ADDRESS <b>Madgelena Randolph 2243 Brunst St.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Severe dehydration.</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Cardio pulmonary failure</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>S/P <del>HEMORRHOIC</del> VASCULAR Accident.</b>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>12/13</b> 19 <b>79</b> to <b>12/14</b> 19 <b>79</b> , that (I) (we) lost saw the deceased alive on <b>12/14/1979</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>N. Sureja</b>		DEGREE		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>N. Sureja M.D.</b>		22e. ADDRESS <b>Provident Hospital</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>12/19/1979</b>		23c. NAME OF CEMETERY OR CREMATORY <b>King Memorial Park</b>	
23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore Co., Maryland</b>					
24. FUNERAL DIRECTOR NAME ADDRESS <b>Wm. C. March F/H 1101 East North Avenue</b>		25a. DATE REC'D. BY REGISTRAR <b>DEC 17 1979</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		7 9 3 0 2 3 3				REG. NO.			
1 DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST Harrison Nathaniel Johnson				2a DATE OF DEATH MONTH DAY YEAR 12 28 79		2b HOUR 3:40 PM	
3 SEX M		4 RACE N		5 DATE OF BIRTH MONTH DAY YEAR 12 27 79		6 AGE (IN YEARS LAST BIRTHDAY)		7 IF UNDER 1 YEAR MONTHS DAYS 1	
8 BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		9 CITIZEN OF WHAT COUNTRY? U.S.A.		10 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		11 BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.			
12 CITY OR TOWN OF DEATH BALTIMORE		13 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) ST. AGNES HOSPITAL				14 USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		15 KIND OF BUSINESS OR INDUSTRY	
16 USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 17a STATE MARYLAND		17b COUNTY A A		17c CITY OR TOWN GLEN BURNIE		18 INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		19 STREET ADDRESS 443 Jumpers Court	
20 FATHER'S NAME KEITH		21 MOTHER'S MAIDEN NAME DARRINITA		22 ADDRESS 443 Jumpers Ct. Glen Burnie, Md.					
23 WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		24 SOCIAL SECURITY NO.		25 INFORMANT KEITH A. JOHNSON					
26 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio respiratory arrest 7670 DUE TO, OR AS A CONSEQUENCE OF (b) severe perinatal asphyxia, cardiogenic shock DUE TO, OR AS A CONSEQUENCE OF (c) post. intracranial hemorrhage shock									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)									
27a DATE OF OPERATION		27b CONDITION FOR WHICH OPERATION WAS PERFORMED				28a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		28b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
29a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		29b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		29c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
30a INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		30b PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		30c LOCATION STREET CITY OR TOWN COUNTY STATE					
31 I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
32a SIGNATURE LMA T. SALCEDO				32b DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				32c DATE SIGNED	
33a PHYSICIAN'S NAME (TYPE OR PRINT) LMA T. SALCEDO				33b ADDRESS 900 CATON AVE. BALTIMORE, MD. 21229					
34 BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		34b DATE 1/2/1980		34c NAME OF CEMETERY OR CREMATORY St. Rest Cemetery		34d LOCATION CITY OR TOWN Hanover		34e COUNTY Md.	
35 FUNERAL DIRECTOR William Reese & Sons Mortuary				35b ADDRESS 821 West St. Annapolis, Md.		35c DATE REC'D. BY REGISTRAR JAN 3 1980		35d REGISTRAR'S SIGNATURE [Signature]	

Resident: Nathaniel Johnson

BALTIMORE CITY

BALTIMORE ST. AGNES HOSPITAL

The Hospital Board

JOHN

WILLIAM

JOHN

JOHN

JOHN A. JOHNSON, JR., President of the Board

2000 CATON AVE., BALTIMORE, MD. 21223

St. Agnes Hospital  
Baltimore, Md.  
Listed in the Baltimore City Directory

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO. 3 0 2 3 4

1. FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>HERMAN ALFRED JOHNSON</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>12-29-79</b>			2b. HOUR <b>9:25 A.M.</b>	
3 SEX <b>MALE</b>		4. RACE <b>BLACK</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>3 29 1921</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>58</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>U.S.A. PHILA. PA.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY</b> MD.	
10. CITY OR TOWN OF DEATH <b>BALTO.</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>U.S. PH. S. HOSP. BALTO. MD.</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>MESSMAN</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>S.A.F.C.</b>	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>PA.</b>		13b. COUNTY <b>PHILA.</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>6655 ROSS ST.</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>MILTON JOHNSON</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>VIRGINIA COURTNEY</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>YES</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>1942-44</b>		17. INFORMANT <b>WIFE</b>		ADDRESS	

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIO-RESPIRATORY ARREST</b> <b>1629</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>METASTATIC CANCER TO BRAIN</b> (c) <b>OST CELL CARCINOMA, LUNG</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
--	--	--

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: **NONE**

19a. DATE OF OPERATION <b>NONE</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>DEC 29</b> , 19 <b>79</b> , to <b>DEC 29</b> , 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.							
22b. SIGNATURE <b>F. H. H. M.D.</b>		DEGREE <b>M.D.</b>		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>12/29/79</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>FLORENCE J. AUSTRIA</b>				22e. ADDRESS <b>3100 WYMAN PARK DR. BALTO., MD</b>			

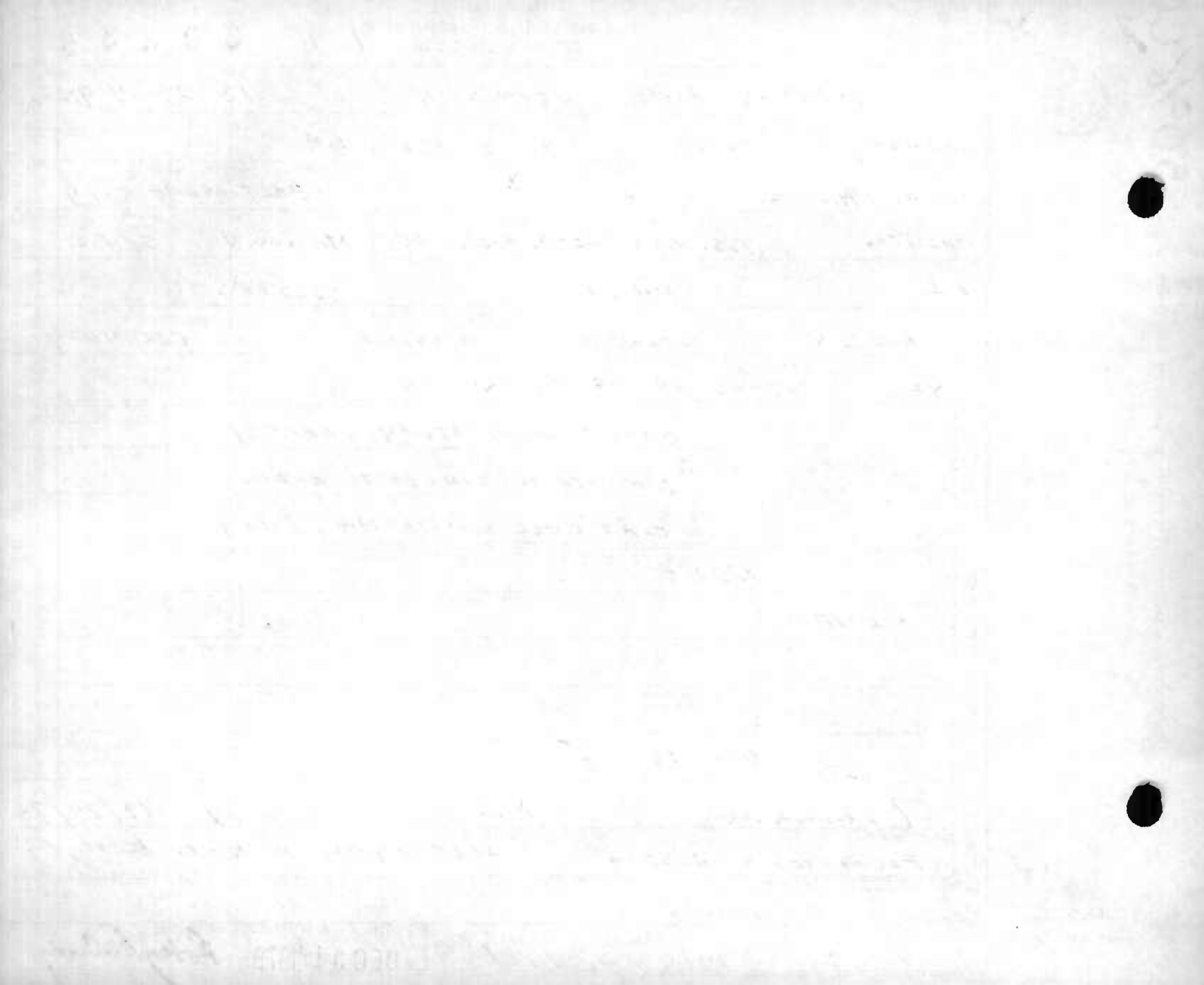
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>REMOVAL</b>		23b. DATE <b>12/29/79</b>		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE	
24. FUNERAL DIRECTOR NAME ADDRESS <b>A.C.S. Phillips, Inc. 1727 N. MONROE ST.</b>				25a. DATE REC'D. BY REGISTRAR <b>DEC 31 1979</b>		25b. REGISTRAR'S SIGNATURE <b>Robert McCreedy</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP



**TO MEDICAL EXAMINER:** THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL HOME. PAGES 4 AND 5 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PW 3. RETAIN PAGE 5 FOR YOUR FILES.

**TO FUNERAL DIRECTOR:** PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND. 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE		3 0 2 3 5	
MEDICAL EXAMINER'S CERTIFICATE OF DEATH		REG. NO.	
1. DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE LAST
JANICE E. JOHNSON			
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS) LAST BIRTHDAY YRS.
female	white	Sept. 6, 1945	34
		IF UNDER 1 YR. MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
California		USA	
10. CITY OR TOWN OF DEATH		9. BALTIMORE CITY OR COUNTY OF DEATH	
Baltimore		Baltimore City	
11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	
University Hospital		Housewife	
13a. STATE		13b. CITY OR TOWN	13c. STREET ADDRESS
Md.		Westminster	1713 Bollinger Road
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST	
E. Dale Guthrey		Patsy Haley	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES)		16b. SOCIAL SECURITY NO.	
No		553-72-5106	
17. INFORMANT		ADDRESS	
Mr. Ronald Johnson		Westminster, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I DEATH WAS CAUSED BY: <u>Gunshot wound of head</u> IMMEDIATE CAUSE (a) _____ (b) _____ (c) _____ Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	
20a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)	
		subject shot self	
21a. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21b. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)	
		home	
21c. LOCATION		CITY OR TOWN COUNTY	
1713 Bollinger Road		Westminister, Maryland	
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .			
ACTUAL SIGNATURE		TITLE (SPECIFY)	DATE SIGNED
<u>Margaret A. Korell</u>		Assistant	12/1/79
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS	
Margaret A. Korell, M.D.		111 Penn Street	
23a. BURIAL CREMATION REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN COUNTY STATE
Cremation	Dec. 2, 79	Security Process	Baltimore, Md.
24. FUNERAL DIRECTOR NAME ADDRESS		25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Eline Funeral Home Reisterstown, Md. 21136		DEC 4 1979	<u>Dorothy McBrady</u>

THE UNIVERSITY OF CHICAGO  
DIVISION OF THE PHYSICAL SCIENCES  
DEPARTMENT OF CHEMISTRY  
CHICAGO, ILLINOIS 60637

TO: THE DIRECTOR, NATIONAL BUREAU OF STANDARDS  
WASHINGTON, D.C. 20535

FROM: DR. J. H. DILLON, JR.  
DEPARTMENT OF CHEMISTRY  
UNIVERSITY OF CHICAGO

SUBJECT: HYDROLYSIS OF POLYESTERS  
IN AQUEOUS SOLUTION

Enclosed for the Bureau are two copies of a report  
on the hydrolysis of polyesters in aqueous solution.

The report contains a summary of the work done  
on this problem during the past few years.

Very truly yours,  
J. H. DILLON, JR.

Enclosure

11 Point Street  
CHICAGO, ILLINOIS 60637

Telephone: 371-1111  
Teletype: 371-1111



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 30236	
1. FOR STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Larry A Johnson, JR						2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR 12 19 79		2b. HOUR M	
3. SEX male		4. RACE black		5. DATE OF BIRTH MONTH DAY YEAR 8 22 58		6. AGE (IN YEARS LAST BIRTHDAY) YRS. 21		IF UNDER 1 YR. MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		2c. DATE PRONOUNCED DEAD MONTH DAY YEAR 12 19 79	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.					
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) University Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE Maryland		13b. COUNTY		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 3031 Rayner Avenue			
14. FATHER'S NAME FIRST MIDDLE LAST Larry A. Johnson, Sr.				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Annette Jefferson							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No				16b. SOCIAL SECURITY NO. N/A		17. INFORMANT ADDRESS Jurina Thomas 2710 Baker Street					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 9654 Gun shot wounds to head and neck DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY (est.) HOUR MIN MONTH DAY YEAR 9:00 P.M. 12/19 1979		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) found shot					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) street		21f. LOCATION STREET CITY OR TOWN COUNTY STATE Tulsa and Liberty Rds, Balto. Co, MD					
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE Margarita A. Korell, M.D.				TITLE (SPECIFY) Assistant				DATE SIGNED 12/20/79			
EXAMINER'S NAME (TYPE OR PRINT)				ADDRESS 111 Penn St., Balto. MD 21201							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 12/24/1979		23c. NAME OF CEMETERY OR CREMATORY King Memorial Park		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Co., Maryland			
24. FUNERAL DIRECTOR NAME Wm. C. March F/H 1101 East North Avenue						25a. DATE REC'D. BY REGISTRAR DEC 26 1979		25b. REGISTRAR'S SIGNATURE Dorothy McCready			

7. 2. 2008

1997

O. S. Inc. 5. 1. :

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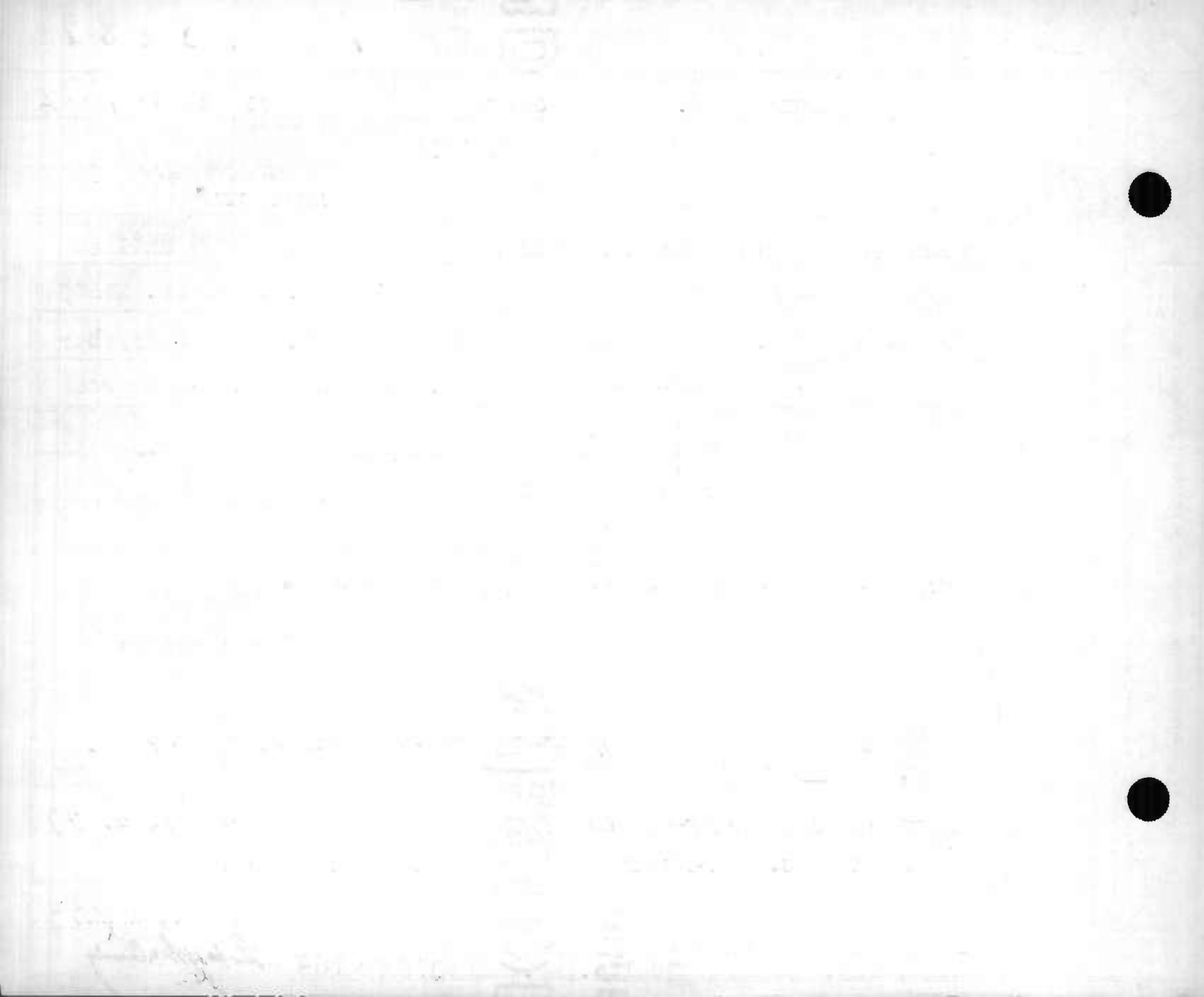
[illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										7 9 3 0 2 3 7			
1. FOR STATE REGISTRAR		REG. NO.											
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR
LOUIS S. JOHNSON								12 26 49					1. 20 AM
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR		8. IF UNDER 24 HRS			
Male		White		June 6, 1914		65		MONTHS		DAYS		HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH							
Maryland		USA				BALTIMORE CITY						MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY							
BALTIMORE		UNION MEMORIAL HOSPITAL		Trainman		Railroad							
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13b. STATE		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS					
Maryland		-		Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		4900 E. Chase St. 21205					
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME											
FIRST MIDDLE LAST Frederick S. Johnson		FIRST MIDDLE LAST Hilda M. Schrieber											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS							
NO		216-01-2918		Ruth W. Johnson, wife, same address									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))													APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY:													
IMMEDIATE CAUSE (a) <u>ASYSTOLE</u>													
410- DUE TO, OR AS A CONSEQUENCE OF													
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last													
(b) <u>INFARCT OF MYO</u>													
DUE TO, OR AS A CONSEQUENCE OF													
(c)													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)													
<u>PULMONARY EDEMA, PROSTATIC CA &amp; METASTASIS</u>													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?							
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)									
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE			
22. I certify that (this hospital) attended the deceased from <u>11-24-</u> 19 <u>49</u> , to <u>12-26</u> 19 <u>49</u> , that (we) last saw the deceased alive on <u>12-26</u> 19 <u>49</u> , and that in (our) opinion death occurred on the date and hour and from the causes stated above. (we) (did) (did not) view the body after death.													
22b. SIGNATURE		DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED							
<u>Dennis J. Chodnicki</u>						12-26-49							
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS											
DENNIS J. CHODNICKI		UNION MEMORIAL HOSPITAL											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN		COUNTY		STATE			
Burial		28 Dec 79		Holly Hills		Baltimore, Md.,				21220			
24. FUNERAL DIRECTOR		ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE							
Schimunek Funeral Home, Inc.		3331 Brehms Lane Balto., Md. 21213		DEC 28 1979		<u>L. J. Kelly</u>							



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 10 days of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										
1. FOR STATE REGISTRAR			79 30238 REG. NO.							
1. DECEASED NAME (TYPE OR PRINT) <b>MACEA</b>			FIRST <b>S</b> MIDDLE <b>H</b> LAST <b>SON</b>			2a. DATE OF DEATH MONTH <b>12</b> DAY <b>21</b> YEAR <b>79</b>			2b. HOUR <b>4:05 PM</b>	
3. SEX <b>M</b>		4. RACE <b>B</b>		5. DATE OF BIRTH MONTH <b>12</b> DAY <b>22</b> YEAR <b>11</b>			6. AGE (IN YEARS LAST BIRTHDAY) <b>67</b> YRS		# UNDER 1 YEAR MONTHS <b></b> DAYS <b></b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>N.C.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH <b>Balto. City</b> MD.			
10. CITY OR TOWN OF DEATH <b>Balto.</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>PROVIDENT HOSPITAL</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE <b>Md.</b>			13b. COUNTY <b>Balto.</b>		13c. CITY OR TOWN <b>Balto.</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>1915 Park Ave.</b>	
14. FATHER'S NAME FIRST <b>John</b> MIDDLE <b>A.</b> LAST <b>Johnson</b>			15. MOTHER'S MAIDEN NAME FIRST <b>Lula</b> MIDDLE <b>Williams</b> LAST <b>Williams</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>			16b. SOCIAL SECURITY NO <b>244-09-5399</b>			17. INFORMANT <b>Retha M. Johnson</b> ADDRESS <b>1915 Park Ave.</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <b>Myocardial Infarction, Cardiogenic</b> <b>410-</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Coronary artery disease</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Shock</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 day</b> <b>5 yrs.</b>										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
19a. DATE OF OPERATION <b>—</b>			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>—</b>				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET <b>12/21/79</b>		21g. CITY OR TOWN <b>Balto.</b>		
21h. COUNTY <b>Balto.</b>			21i. STATE <b>MD.</b>							
22a. I certify that (I) (this hospital) attended the deceased from <b>12/21/79</b> to <b>12/21/79</b> , that (I) (we) last saw the deceased alive on <b>12/21/79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <b>Robert W. March</b>			DEGREE <b>FACS (C)</b>			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>12/21/79</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>ROBERT W. MARCH</b>			22e. ADDRESS <b>PROVIDENT HOSPITAL, 2600 Liberty Ave, BALTIMORE</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>12/27/79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>King Mem. Pk.</b>		23d. LOCATION CITY OR TOWN <b>Baltimore Co., Md.</b>			
24. FUNERAL DIRECTOR NAME <b>Wm C March F/H</b>			ADDRESS <b>1101 E. North Ave.</b>			25a. DATE REC'D. BY REGISTRAR <b>DEC 26 1979</b>		25b. REGISTRAR'S SIGNATURE <b>Robert W. March</b>		

1975 10 10

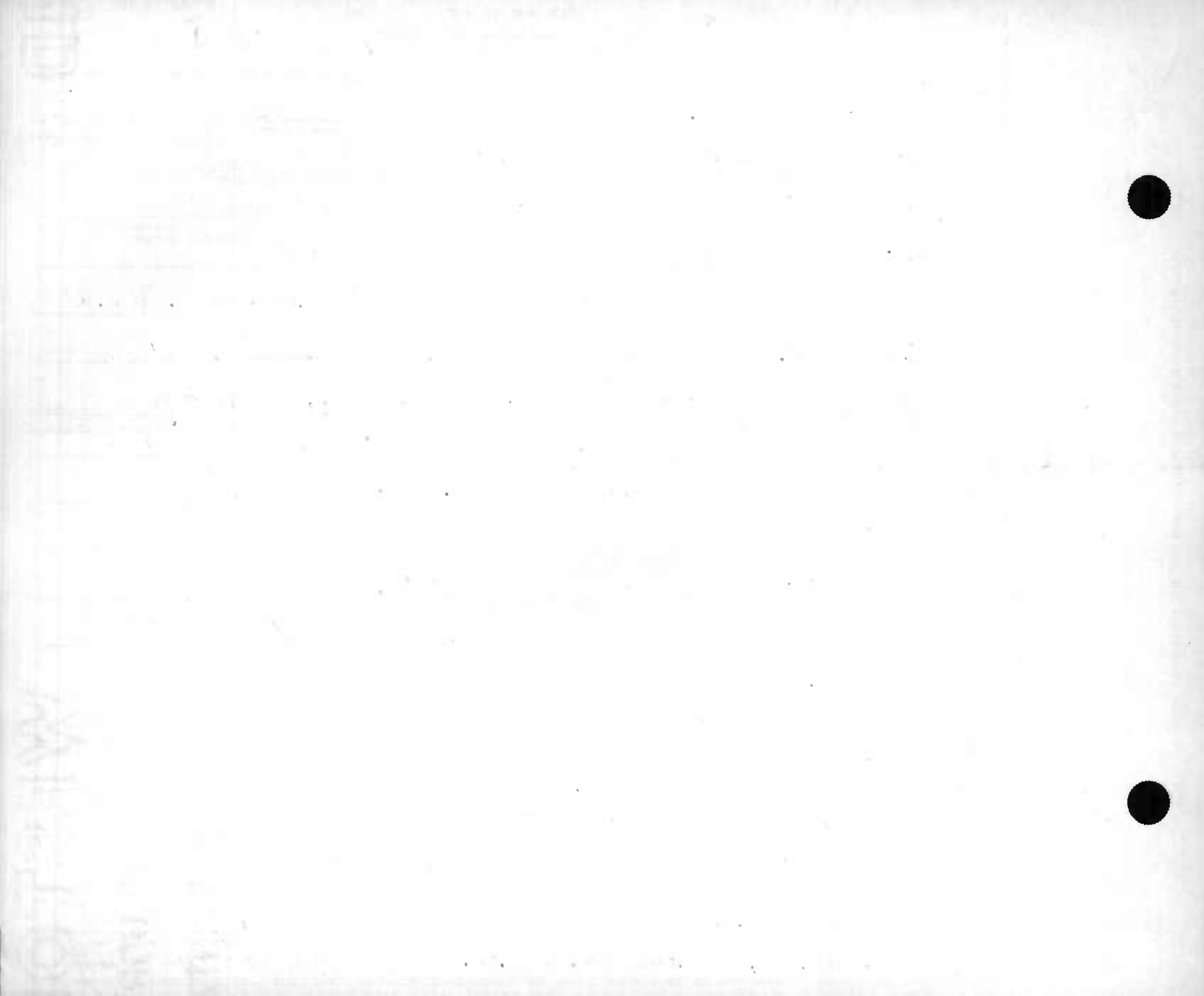
TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										7 9 3 0 2 3 9	
1. DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST	2a. DATE OF DEATH MONTH DAY YEAR				2b. HOUR		
Margaret J. Johnson					12-5-1979				11:58 P.M.		
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR		8. IF UNDER 24 HRS			
Female	White	March 6, 1905		74		YRS. MONTHS DAYS		HOURS MIN.			
9a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	9b. CITIZEN OF WHAT COUNTRY?	10. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		11. BALTIMORE CITY OR COUNTY OF DEATH		12. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		13. KIND OF BUSINESS OR INDUSTRY			
Maryland	USA	WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		Baltimore City MD.		Housewife					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		13. KIND OF BUSINESS OR INDUSTRY					
Baltimore		John L. Decker Medical Center		Housewife							
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS			
Maryland				Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		7849 S. Charles St. Balto. Md			
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS			
John T. Bonce		Elizabeth O'Hara		No		Unknown		Mr. Donald E. Johnson, Same as above			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			
1590		1590		1590		1590		1590			
PART I. DEATH WAS CAUSED BY:		PART I. DEATH WAS CAUSED BY:		PART I. DEATH WAS CAUSED BY:		PART I. DEATH WAS CAUSED BY:		PART I. DEATH WAS CAUSED BY:			
IMMEDIATE CAUSE (a)		IMMEDIATE CAUSE (a)		IMMEDIATE CAUSE (a)		IMMEDIATE CAUSE (a)		IMMEDIATE CAUSE (a)			
Chronic Renal Failure		Chronic Renal Failure		Chronic Renal Failure		Chronic Renal Failure		Chronic Renal Failure			
DUE TO, OR AS A CONSEQUENCE OF		DUE TO, OR AS A CONSEQUENCE OF		DUE TO, OR AS A CONSEQUENCE OF		DUE TO, OR AS A CONSEQUENCE OF		DUE TO, OR AS A CONSEQUENCE OF			
(b) possible recurrent Carcinoma of Bowel		(b) possible recurrent Carcinoma of Bowel		(b) possible recurrent Carcinoma of Bowel		(b) possible recurrent Carcinoma of Bowel		(b) possible recurrent Carcinoma of Bowel			
DUE TO, OR AS A CONSEQUENCE OF		DUE TO, OR AS A CONSEQUENCE OF		DUE TO, OR AS A CONSEQUENCE OF		DUE TO, OR AS A CONSEQUENCE OF		DUE TO, OR AS A CONSEQUENCE OF			
(c)		(c)		(c)		(c)		(c)			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)		PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)		PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)		PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)		PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)			
Dehydration, Depression		Dehydration, Depression		Dehydration, Depression		Dehydration, Depression		Dehydration, Depression			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		20c. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			
		19									
22a. I certify that (1) (this hospital) attended the deceased from 9-25, 1979 to 12-5, 1979, that (1) (we) lost saw the deceased alive on 12-3-1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (2) (we) (did) (did not) view the body after death.		22b. SIGNATURE		22c. DATE SIGNED		22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS			
		Alfred J. Daniels MD		12/5/79		Alfred J. Daniels MD		510 E. Fort Ave. Baltimore Md 21203			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN		23e. COUNTY STATE			
Burial		Dec. 8, 1979		Holy Cross Cemetery		Baltimore,		Maryland			
24. FUNERAL DIRECTOR		24b. ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		25c. REGISTRAR'S SIGNATURE			
McCurly Funeral Home, 130 E. Fort Ave. Balto. Md.				DEC 11 1979		T. J. McCurdy					





TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, DIRECTOR OF HEALTH AND MENTAL HYGIENE, BALTIMORE, MD. 21201, MUST BE ADVISED. THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, DIRECTOR OF HEALTH AND MENTAL HYGIENE, BALTIMORE, MD. 21201, MUST BE ADVISED. THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, DIRECTOR OF HEALTH AND MENTAL HYGIENE, BALTIMORE, MD. 21201, MUST BE ADVISED.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										30240 REG. NO.	
1- DECEASED NAME FIRST MIDDLE LAST Roscoe Walter Johnson										2a. DATE KNOWN OF DEATH MONTH DAY YEAR 12 23 1979	
3. SEX Male		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR Jan. 24, 1930		6. AGE (IN YEARS) LAST BIRTHDAY 49 YRS.		7. IF UNDER 1 YR. IF UNDER 24 HRS. MONTHS DAYS HOURS MIN.		2b. DATE PRONOUNCED DEAD MONTH DAY YEAR 12 23 1979	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City, MD.					
10. CITY OR TOWN OF DEATH Baltimore City		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) University Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Laborer		12b. KIND OF BUSINESS OR INDUSTRY Waterproofing			
13a. STATE Maryland		13b. COUNTY		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 1503 Mosher Street			
14. FATHER'S NAME FIRST MIDDLE LAST Mc Alister Johnson				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lucille Johnson							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. 215-26-3644		17. INFORMANT ADDRESS Robert Johnson-Hillcrest Hgts, MD.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Smoke and soot inhalation</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 1:38 PM 12 23 1979		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) house fire					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) home		21f. LOCATION STREET CITY OR TOWN COUNTY STATE 1503 W. Mosher St. Balto. MD					
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE <i>Thomas D. Smith</i>				TITLE (SPECIFY) M.D. Deputy Chief				DATE SIGNED 12/23/79			
EXAMINER'S NAME (TYPE OR PRINT) Thomas D. Smith, M.D.				ADDRESS 111 Penn St. Balto., MD.							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12-27-1979		23c. NAME OF CEMETERY OR CREMATORY Sacred Heart Cemetery				23d. LOCATION CITY OR TOWN COUNTY STATE La Plata, Charles, MD.			
24. FUNERAL DIRECTOR NAME ADDRESS Arehart Funeral Home, Inc. La Plata, MD.				25a. DATE REC'D. BY REGISTRAR JAN 2 1980		25b. REGISTRAR'S SIGNATURE <i>John A. Bandy</i>					

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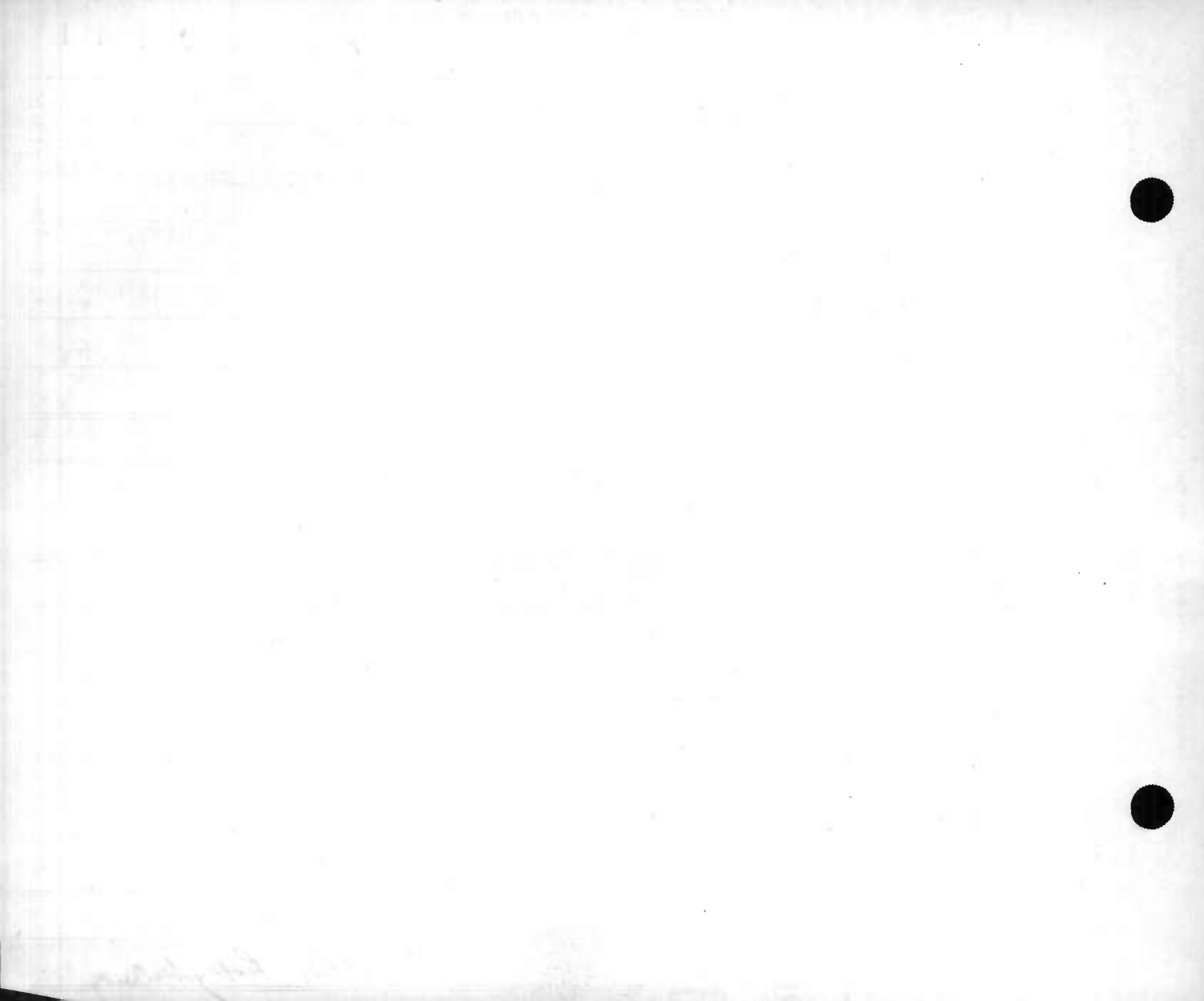
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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										7 9 3 0 2 4 1		
1. FOR STATE REGISTRAR			REG. NO.									
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH			MONTH DAY YEAR		2b. HOUR	
BABY GIRL			JONAS			12 03 79			11:15a		M	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS		
F		CAUCASIAN		12 03 79		YRS.		MONTHS DAYS		HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH						
MARYLAND		U.S.				BALTIMORE CITY MD.						
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		
BALTIMORE		SINAI HOSP. OF BALTIMORE										
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)			13a. STATE			13b. COUNTY			13c. CITY OR TOWN			
MARYLAND			BALTIMORE			BOWINGS MILL			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME			13e. STREET ADDRESS			13f. STREET ADDRESS			
FIRST MIDDLE LAST			FIRST MIDDLE LAST			9, WENGATE COURT						
DONALD			JONAS			CATHI			JONAS			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO			17. INFORMANT			ADDRESS			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY:										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
IMMEDIATE CAUSE (a) ANOXIA												
7689 DUE TO, OR AS A CONSEQUENCE OF										1 hr 45 min		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.												
DUE TO, OR AS A CONSEQUENCE OF												
DUE TO, OR AS A CONSEQUENCE OF												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)												
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?				
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)						
			P.M. 19									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN COUNTY STATE			
22a. I certify that (I (this hospital) attended the deceased from 12-3-1979 to 12-3-1979, that (I) (we) last saw the deceased alive on 12-3-1979, and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE						DEGREE			22c. DATE SIGNED			
Kamakshi N. Vaidyanath						ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			12/3/79			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)						22e. ADDRESS						
KAMAKSHI N. VAIDYANATH						SINAI HOSP. OF BALTIMORE BALTIMORE, MD. 21215						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION CITY OR TOWN COUNTY STATE				
CREMATION			12-31-79		SINAI Hospital			Baltimore, Md.				
24. FUNERAL DIRECTOR NAME						24b. DATE REC'D. BY REGISTRAR			24c. REGISTRAR'S SIGNATURE			
						JAN 4 1980			Ricky Bellamy			

BP \_\_\_\_\_

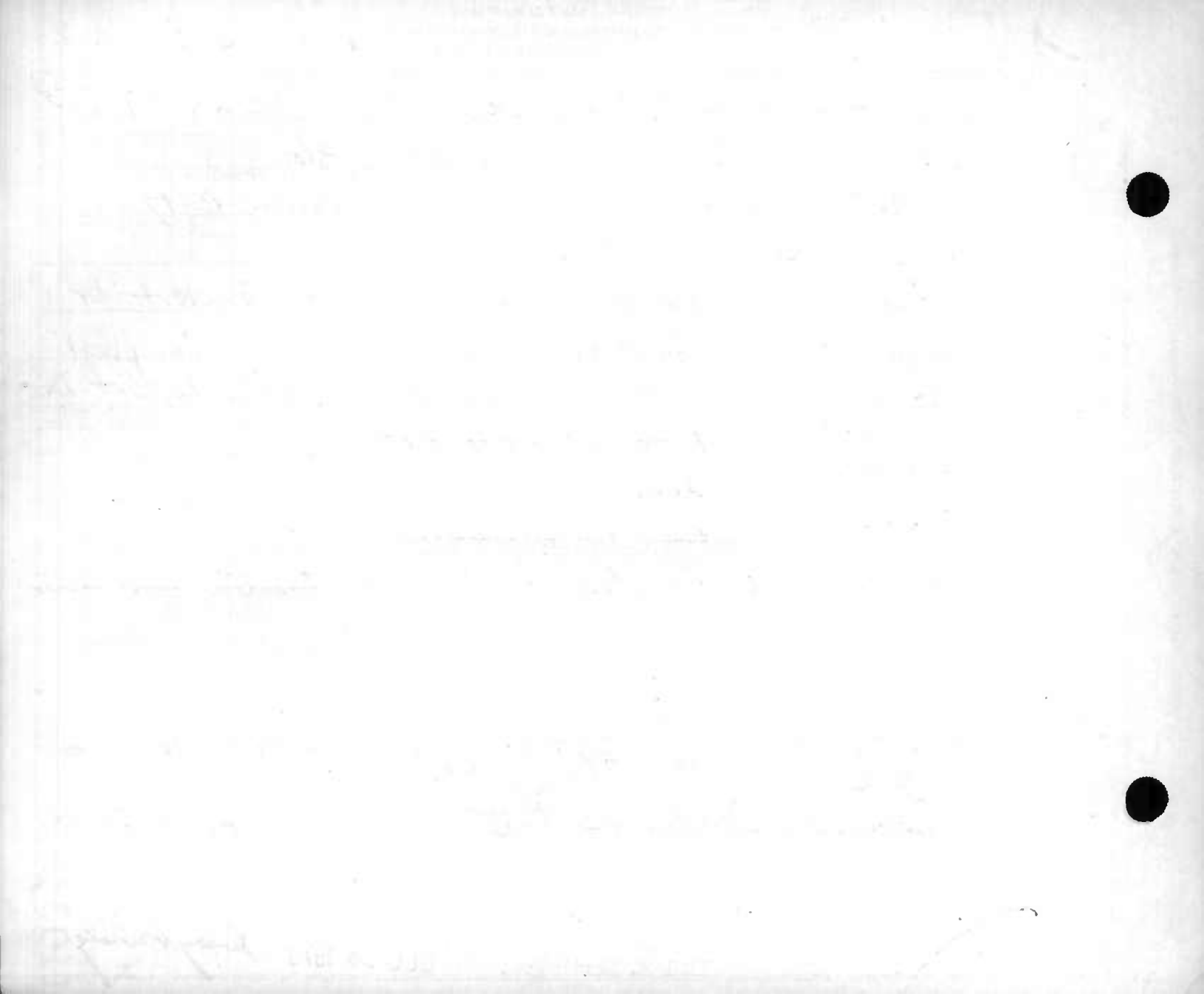


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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
<div> <div>1- STATE REGISTRAR</div> <div> <div>7 9 3 0 2 4 2</div> <div>REG. NO.</div> </div> </div>									
1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Annie L. Baker Jones</b>					2a DATE OF DEATH MONTH DAY YEAR <b>12 24 79</b>		2b HOUR <b>35</b> M		
3 SEX <b>F</b>		4 RACE <b>B</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>5 12 43</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>36</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>N.C.</b>		7b CITIZEN OF WHAT COUNTRY? <b>USA</b>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>Balto. City</b> MD.			
10 CITY OR TOWN OF DEATH <b>Balto.</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>DEATON MEDICAL CENTER</b>				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE <b>Md</b> 13b COUNTY <b>Balto.</b> 13c CITY OR TOWN <b>Balto.</b>					13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS <b>2877 Bookert Dr.</b>		
14 FATHER'S NAME FIRST MIDDLE LAST <b>John Gardner</b>					15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Alma Campbell</b>				
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES) <b>216-42-4301</b>		17 INFORMANT <b>Alma Baker</b>			ADDRESS <b>2877 Bookert Dr.</b>		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Respiratory arrest-</b> <b>2500</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>Sepsis-</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Possible meningitis-</b>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>Uncontrolled diabetes; brain death; insulin overdoses</b>									
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE					
22a I certify that (I) (this hospital) attended the deceased from <b>7-24-</b> 19 <b>79</b> , to <b>12-24-</b> 19 <b>79</b> , that (I) (we) saw the deceased alive on <b>12-24</b> 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b SIGNATURE <b>Joanne E. Williams M.D.</b>						22c DATE SIGNED <b>12-24-79</b>			
22d PHYSICIAN'S NAME (TYPE OR PRINT)						22e ADDRESS			
23a BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b DATE <b>12/28/79</b>		23c NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cemetery</b>		23d LOCATION CITY OR TOWN COUNTY STATE <b>Anne Arundel Co. Md.</b>			
24 FUNERAL DIRECTOR NAME <b>Wm C March F/H</b>				ADDRESS <b>1101 E. North Ave.</b>		25a DATE REC'D. BY REGISTRAR <b>DEC 28 1979</b>		25b REGISTRAR'S SIGNATURE <b>[Signature]</b>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

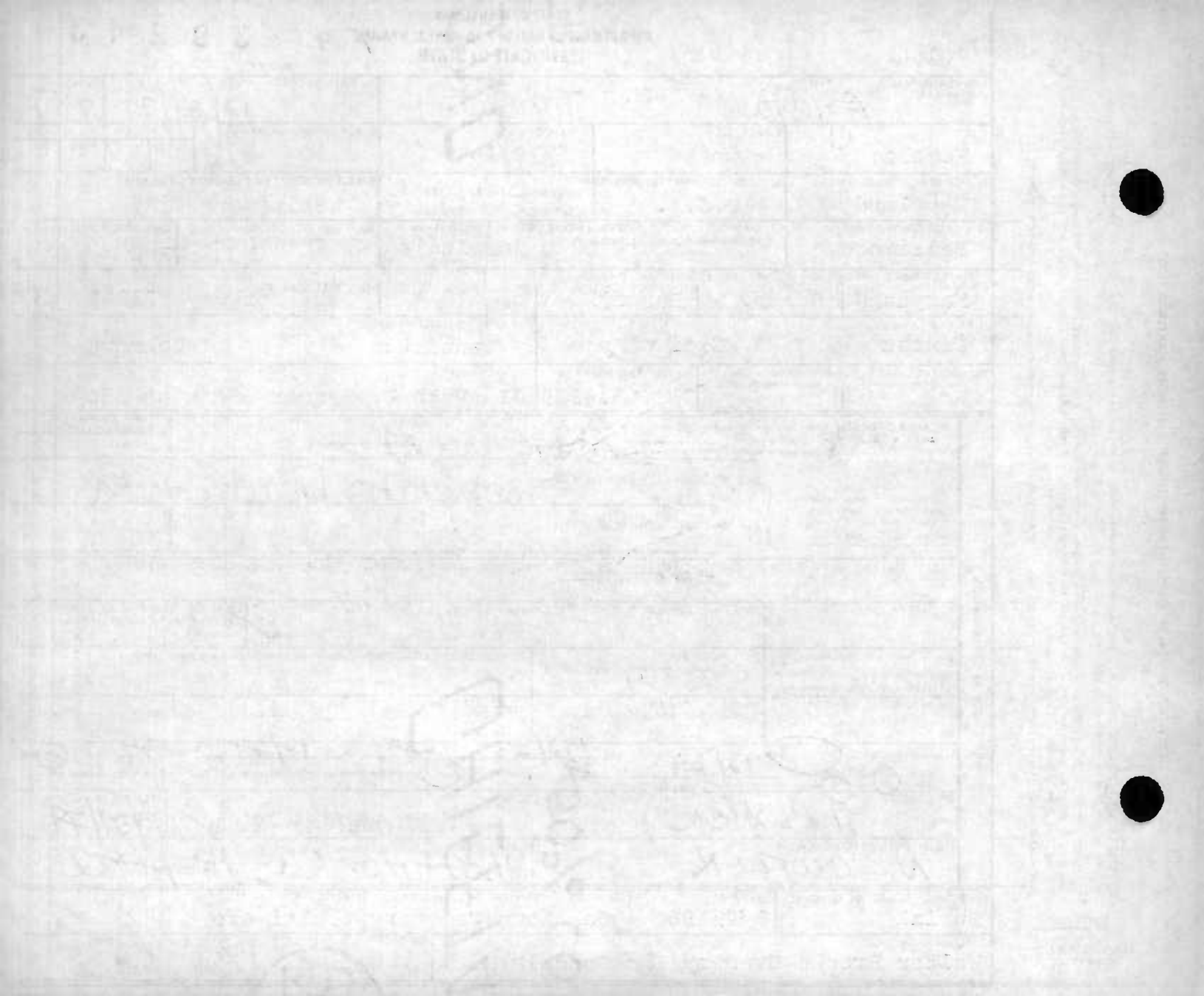
STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1 - FOR STATE REGISTRAR									
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Augusta Amelia Jones</i>					2a. DATE OF DEATH MONTH DAY YEAR <i>12/29/79</i>		2b. HOUR <i>4:35 P.M.</i>		
3. SEX <i>Female</i>		4. RACE <i>white</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>5/18/1889</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>90</i> YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Maryland</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Baltimore City</i> MD.			
10. CITY OR TOWN OF DEATH <i>Baltimore</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Baltimore City Hospitals</i>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>HOUSEWIFE</i>		12b. KIND OF BUSINESS OR INDUSTRY	
13. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a. STATE <i>Maryland</i>		13b. COUNTY <i>Balto.</i>		13c. CITY OR TOWN <i>Dundalk</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <i>3426 Yorkway 21222</i>	
14. FATHER'S NAME FIRST MIDDLE LAST <i>Ernest Gleitsman</i>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Henrietta Unknown</i>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i>		16b. SOCIAL SECURITY NO. <i>215.50.9359</i>		17. INFORMANT ADDRESS <i>JI Ruth L. Kerner--Same as 13e</i>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>cardiac arrest</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>metastatic breast cancer</i> DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <i>12/23</i> 19 <i>79</i> , to <i>12/29</i> 19 <i>79</i> , that (I) (we) last saw the deceased alive on <i>12/29</i> 19 <i>79</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death.									
22b. SIGNATURE <i>N. Cutler</i>		DEGREE				ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <i>12/29/79</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>N. CUTLER</i>				22e. ADDRESS <i>Baltimore City Hospital</i>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>1/2/1980</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Oak Lawn Cemetery</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Baltimore Md.</i>			
24. FUNERAL DIRECTOR NAME <i>Walter Brooks Bradley Inc</i>						25a. DATE REC'D. BY REGISTRAR <i>IAN 7 1980</i>		25b. REGISTRAR'S SIGNATURE <i>Pitney McCurdy</i>	

MEDICAL CERTIFICATION

29

1

BP





DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

7 9 3 0 2 4 4

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT)		FIRST DORA	MIDDLE	LAST JONES	2a. DATE OF DEATH		MONTH 12	DAY 19	YEAR 79	2b. HOUR 11:35 PM	
3. SEX F.	4. RACE B.	5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS.		
		MONTH 04 DAY 30 YEAR 98			81 YRS.		MONTHS		DAYS		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) North Carolina	7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.						
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SINAI HOSP OF BALTIMORE			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY Home				
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS					
13a. STATE MD		13b. COUNTY		YES <input type="checkbox"/> NO <input type="checkbox"/>		3410 HOMES AVE 21217					
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME							
FIRST William		MIDDLE		LAST Weaver		FIRST Martha		MIDDLE		LAST Weaver	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 217-30-3464		17. INFORMANT ADDRESS MR. HERBERT D. JONES		3410 HOMES AVE					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) HISTIOCYTIC LYMPHOMA 2000 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 yrs.											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). PNEUMONIA											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
						YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WORKING <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (1) this hospital attended the deceased from 11/30 1979 to 12/19/79 19____, that (1) was lost saw the deceased alive on 12/19 1979, and that in (my) own opinion death occurred on the date and hour and from the causes stated above, (1) (we) did (did not) view the body after death.											
22b. SIGNATURE USAA RAO				DEGREE MD				ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 12/19/79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS							
USAA RAO				SINAI HOSP OF BALTIMORE.							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12-24-79		23c. NAME OF CEMETERY OR CREMATORY Arbutus Mem. Pk.		23d. LOCATION CITY OR TOWN COUNTY STATE Balto County, Maryland					
24. FUNERAL DIRECTOR NAME Herbert E. Nutter 3035 W. North Ave.				25a. DATE REC'D. BY REGISTRAR DEC 27 1979		25b. REGISTRAR'S SIGNATURE [Signature]					

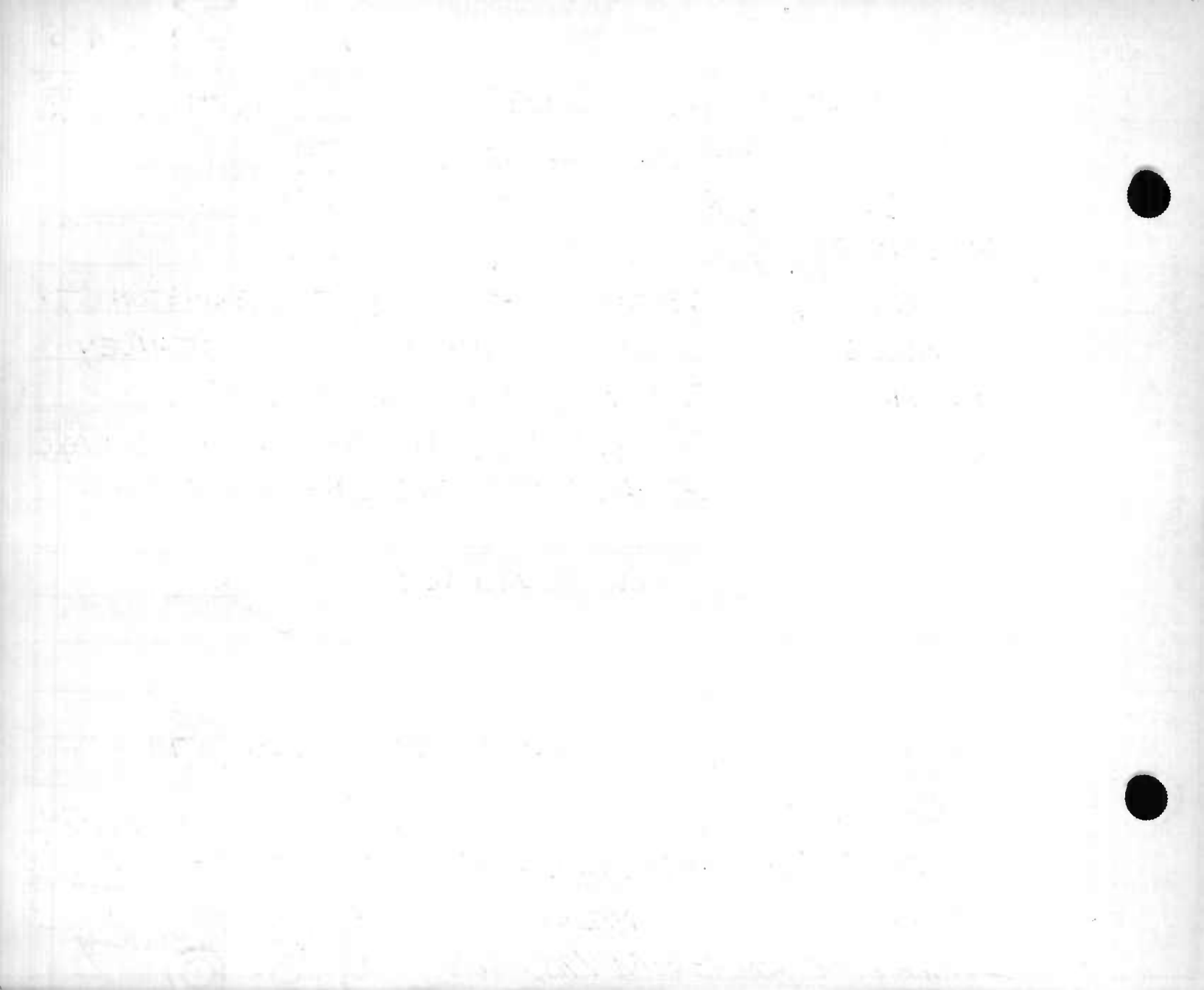


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
1. FOR STATE REGISTRAR		7 9 3 0 2 4 5 REG. NO.									
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR	
ERNEST H. JONES								12-11-79		6 05 A.M.	
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY) YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
MALE		BLACK		4 15 00		79					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
MD.		USA				CITY					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
BALTIMORE		BON SECOURS HOSP.				Retired					
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS	
MD.				BALTIMORE						1915 W. LEXINGTON ST.	
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST									
WILLIE JONES		ANNIE STANLEY									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS							
UNKNOWN		217 010677		MEDICAL RECORDS							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 496- RESPIRATORY INSUFFICIENCY DUE TO, OR AS A CONSEQUENCE OF (b) CHRONIC OBSTRUCTIVE LUNG DISEASE DUE TO, OR AS A CONSEQUENCE OF (c) YEARS APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 DAYS											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) COR PULMONALE											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
		P.M. 19									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE	
22a. I certify that (I) (this hospital) attended the deceased from 12-07-19-79 to 12-11-19-79, that (I) (we) last saw the deceased alive on 12-10-19-79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE		DEGREE				22c. DATE SIGNED					
Oscar E. Ferdinandini M.D.		M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				12-11-79					
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS									
OSCAR E. FERNANDINI M.D.		2025 W. FAYETTE ST. BALTO., MD 21223									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN		COUNTY		STATE	
BURIAL		12-14-79		NOT CALVARY Cem.		Glen Burnie				MD	
24. FUNERAL DIRECTOR NAME		ADDRESS				25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
ISAIAH L. BROWN		450N PA. 1913 W BALTO				DEC 17 1979		F. J. Kelly			



DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

7 9 3 0 2 4 6

REG. NO.

1. FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>ETTA G. JONES</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>12/19/79</b>			2b. HOUR <b>1:00 P.M.</b>				
3. SEX <b>FEMALE</b>		4. RACE <b>BLACK</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>5 6 92</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>87</b> YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN IF UNDER 24 HRS		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MARYLAND</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY</b> MD.				
10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>1622 W. LAFAYETTE AVE.</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>DOMESTIC</b>		12b. KIND OF BUSINESS OR INDUSTRY		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>MD</b>			13b. COUNTY <b>BALTO.</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>1622 W. LAFAYETTE AVE.</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>Joseph Montgomery</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>SUSIE Johnson (Montgomery)</b>			16. ADDRESS <b>Balt. Md.</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>220-30-4656A</b>		17. INFORMANT <b>Laurene Hardy</b>				ADDRESS <b>6816-Yatauruba Rd.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac Arrhythmia</b> <b>4140</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost DUE TO, OR AS A CONSEQUENCE OF (b) <b>Arteriosclerotic Heart Disease</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Hypertension + Diabetic Mellitus</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>15 minutes</b> <b>15 YEARS</b>										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
19a. DATE OF OPERATION <b>Sept 30, 19 67</b>			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>Sept 30, 19 67</b> , to <b>Dec. 19, 19 79</b> , that (I) (we) lost saw the deceased alive on <b>Dec. 18, 19 79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <b>Roland T. Smoot, M.D.</b>						DEGREE <b>MD</b>		22c. DATE SIGNED <b>12/19/79</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>ROLAND T. SMOOT, M.D.</b>						22e. ADDRESS <b>2300 GARRISON BLVD 21216</b>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>			23b. DATE <b>12-23-79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Hope Brypt. Ch. Len</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore Montgomery Charles County</b>			
24. FUNERAL DIRECTOR NAME <b>Montgomery Bros. Funeral Home - St. N.W.</b>			ADDRESS <b>719-Kenn</b>		25. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE <b>DEC 28 1979</b>					

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 2 and 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.



DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

7 9 3 0 2 4 7

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>FRIEDA + JONES</b>			2a. DATE OF DEATH MONTH <b>12</b> DAY <b>26</b> YEAR <b>79</b>			2b. HOUR <b>11.00 AM</b>		
3 SEX <b>F</b>		4 RACE <b>N</b>		5 DATE OF BIRTH MONTH <b>6</b> DAY <b>14</b> YEAR <b>1963</b>			6 AGE (IN YEARS LAST BIRTHDAY) <b>16</b> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>BALTIMORE, MD.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY</b> MD.		
10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>MT. WASHINGTON PED HOSPITAL</b>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>-</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>-</b>	
13a. STATE <b>MARYLAND</b>			13b. COUNTY <b>N/A</b>		13c. CITY OR TOWN <b>BALTIMORE</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET ADDRESS <b>2910 WINCHESTER STREET</b>								
14 FATHER'S NAME FIRST <b>WILLIAM</b> MIDDLE <b>JONES</b> LAST <b>JONES</b>				15 MOTHER'S MAIDEN NAME FIRST <b>EVELYN A.</b> MIDDLE <b>COVINGTON</b> LAST <b>COVINGTON</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>N/A</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>N/A</b>		17. INFORMANT ADDRESS <b>MRS. EVELYN A. COVINGTON 2910 WINCHESTER ST.</b>				
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>DAWSON'S ENCEPHALITIS - TERMINAL</b> <b>0462</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>STAGE</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <b>-</b> DUE TO, OR AS A CONSEQUENCE OF PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>3 years</b>
19a. DATE OF OPERATION <b>-</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <b>8/1</b> , 19 <b>77</b> , to <b>12/26</b> , 19 <b>79</b> , that (I) (we) last saw the deceased alive on <b>12/26</b> , 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE <b>Patchani Swichun MD</b>				DEGREE <b>MD</b> ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED <b>12/26/79</b>
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>P. SURIEH MORN, M.D.</b>				22e. ADDRESS <b>MT. WASHINGTON PED. HOSPITAL</b>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>12/29/79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>KING MEM. PARK</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>BALTIMORE, MD.</b>		
24. FUNERAL DIRECTOR NAME <b>LEROY O. DYETT FUN. HOME 4600 LIB. HGHTS. AVE.</b>				25a. DATE REC'D. BY REGISTRAR <b>DEC 27 1979</b>		25b. REGISTRAR'S SIGNATURE <b>Patchani Swichun</b>		

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO. 30248

1 - FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) George A. Jones			2a. DATE OF DEATH MONTH DAY YEAR 12 3 79		2b. HOUR M
3. SEX M	4. RACE B	5. DATE OF BIRTH MONTH DAY YEAR 6 15 12		6. AGE (IN YEARS LAST BIRTHDAY) 67 YRS IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Va.	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.	
10. CITY OR TOWN OF DEATH Balto.		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 2723 Riggs Avenue		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	
13a. STATE Md.		13b. COUNTY	13c. CITY OR TOWN Balto.	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST George A. Jones		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Bertha Green			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO WWII 212-14-2030		17. INFORMANT ADDRESS Hazel N. Jones 2723 Riggs Ave.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Probable acute myocardial infarction</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>ACVD &amp; atherosclerosis</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>A</u> 410- Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>2 yrs.</u>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Carcinoma of bronchus (dx 11/16/79)</u>					
19a. DATE OF OPERATION <u>11/16/79</u>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Cx of bronchus</u>		20. AUTOPOST YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>8/15/77</u> to <u>12/3/79</u> , that (I) <u>did</u> <input checked="" type="checkbox"/> saw the deceased alive on <u>11/24/79</u> , and that in my <u>own</u> opinion death occurred on the date and hour and from the causes stated above, (I) <u>we</u> <input checked="" type="checkbox"/> did not view the body after death.					
22b. SIGNATURE <u>Elitah Samuels</u>		DEGREE M.D.		22c. DATE SIGNED <u>12/3/79</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Elitah Samuels</u>		22e. ADDRESS <u>2700 Garrison Blvd.</u>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12/7/79		23c. NAME OF CEMETERY OR CREMATORY King Mem. Pk.	
23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Co., Md.		24. FUNERAL DIRECTOR NAME Wm C March F/H		25a. DATE REC'D. BY REGISTRAR DEC 4 1979	
25b. REGISTRAR'S SIGNATURE <u>Ruby Ruby</u>					

1606 BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed within 72 hours after death. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

7

Received of the  
U.S. DEPT. OF AGRICULTURE  
the sum of \$100.00  
for the purchase of  
land in the State of  
California.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO. 30249

FOR 1 - STATE REGISTRAR		2a. DATE OF DEATH		MONTH DAY YEAR		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		12-17-79		100 A M	
3. SEX F		4. RACE B		5. DATE OF BIRTH MONTH DAY YEAR 11 29 1887		6. AGE (IN YEARS LAST BIRTHDAY) 92 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.	
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Mercy Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE MARYLAND		13b. COUNTY		13c. CITY OR TOWN BALTIMORE		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST GEORGE BUTLER		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST GRACE TOWE		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO		16b. SOCIAL SECURITY NO. 219-54-3609	
17. INFORMANT ADDRESS Annapolis, Maryland		17. INFORMANT MR. FRANCIS NOEL 1957 Forest Dr. Maryland		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cardiopulmonary arrest</u> 2500 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cerebral damage secondary to severe hypoglycemia</u> (c) <u>adult onset diabetes mellitus</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>large left pleural effusion, etiology unknown</u>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>12-12</u> , 19 <u>79</u> , to <u>12-17</u> , 19 <u>79</u> , that (I) (we) last saw the deceased alive on <u>12-17</u> , 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Kathleen H. Miller, MD		DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 12-17-79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) K. H. Miller		22e. ADDRESS Mercy Hospital					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 12-21-1979		23c. NAME OF CEMETERY OR CREMATORY Mt. Auburn Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Maryland	
24. FUNERAL DIRECTOR NAME WILLIAM REESE & SONS MORTUARY, P.A.		ADDRESS Annapolis, Md.		25. DATE REC'D. BY REGISTRAR DEC 20 1979		25b. REGISTRAR'S SIGNATURE Henry McCready	

MEDICAL CERTIFICATION

BP



FIG. 1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filled in by the funeral director, completely filled in by the funeral director, and completely filled in by the funeral director. Pages 1 and 2 should be filled in by the funeral director, completely filled in by the funeral director, and completely filled in by the funeral director.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled in by the funeral director, completely filled in by the funeral director, and completely filled in by the funeral director.

with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 7 9 3 0 2 5 0	
1. FOR STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST JACK R. Jones						2a. DATE OF DEATH MONTH DAY YEAR 12-4-79		2b. HOUR 1:15 A.M.	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR May 24, 1925		6. AGE (IN YEARS LAST BIRTHDAY) 54 YRS		7. IF UNDER 1 YEAR MONTHS DAYS		8. IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Kentucky		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.					
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Mercy Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Bricklayer		12b. KIND OF BUSINESS OR INDUSTRY Const.			
13a. STATE MD.						13b. COUNTY A.A.		13c. CITY OR TOWN Pasadena		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Charles E. Jones						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Elsie Jones					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WWT		17. INFORMANT Macy F. Jones - Sec. 13		ADDRESS					
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arrhythmia</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>CAT Cell Ca with METASTASIS</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>1629</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Minutes 7 months	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (c). <u>Chronic Arteriosclerosis</u>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <u>11/26</u> , 19 <u>77</u> , to <u>12/4</u> , 19 <u>77</u> , that (I) (we) lost saw the deceased alive on <u>12/4</u> , 19 <u>77</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE S. Scalia						DEGREE		22c. DATE SIGNED 12/4/79		22d. PHYSICIAN'S NAME (TYPE OR PRINT) S. Scalia	
22e. ADDRESS Mercy Hospital						22f. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12-7-79		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore A.A. MD.					
24. FUNERAL DIRECTOR NAME Robert S. Barranco		ADDRESS 501 Ritchie Hwy Severna Park		25a. DATE REC'D. BY REGISTRAR DEC 7 1979		25b. REGISTRAR'S SIGNATURE [Signature]					

MEDICAL CERTIFICATION

M

100

COLLECTION

NOTICE

REG. NO.

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>	23b. DATE <b>1/5/80</b>	23c. NAME OF CEMETERY OR CREMATORY <b>KING MEMORIAL PARK CEM.</b>	23d. LOCATION CITY OR TOWN <b>BALTIMORE, MARYLAND</b>	COUNTY	STATE
24. FUNERAL DIRECTOR NAME <b>LEROY O. DYETT &amp; SON</b>		ADDRESS <b>4600 LIBERTY HGHTS AVE.</b>	25a. DATE REC'D. BY REGISTRAR <b>JAN 4 1980</b>	25b. REGISTRAR'S SIGNATURE <i>Robert Helms</i>	

**TO MEDICAL EXAMINER:** THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE MEDICAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES.

**TO FUNERAL DIRECTOR:** PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 100 PENNSYLVANIA STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

2

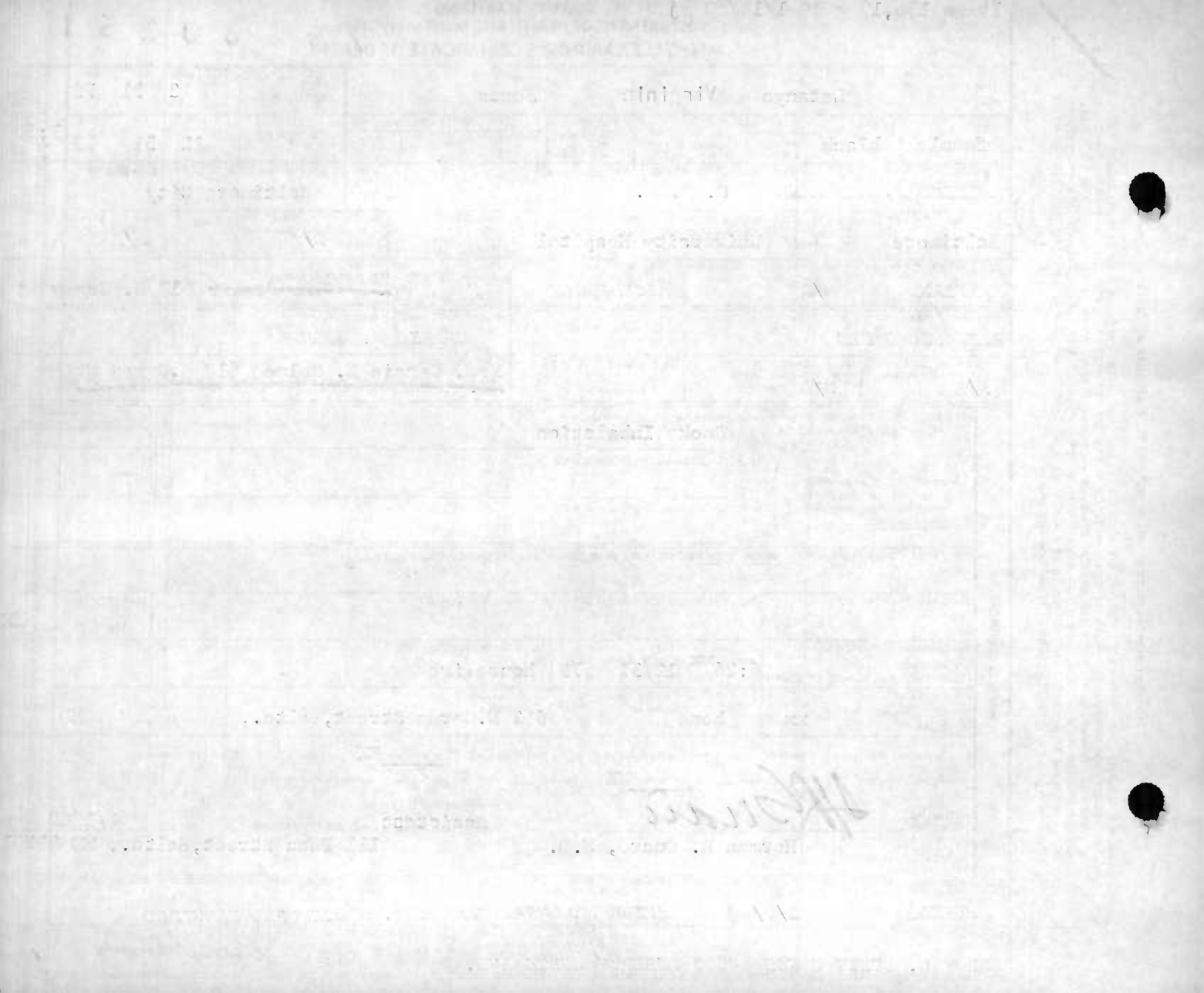
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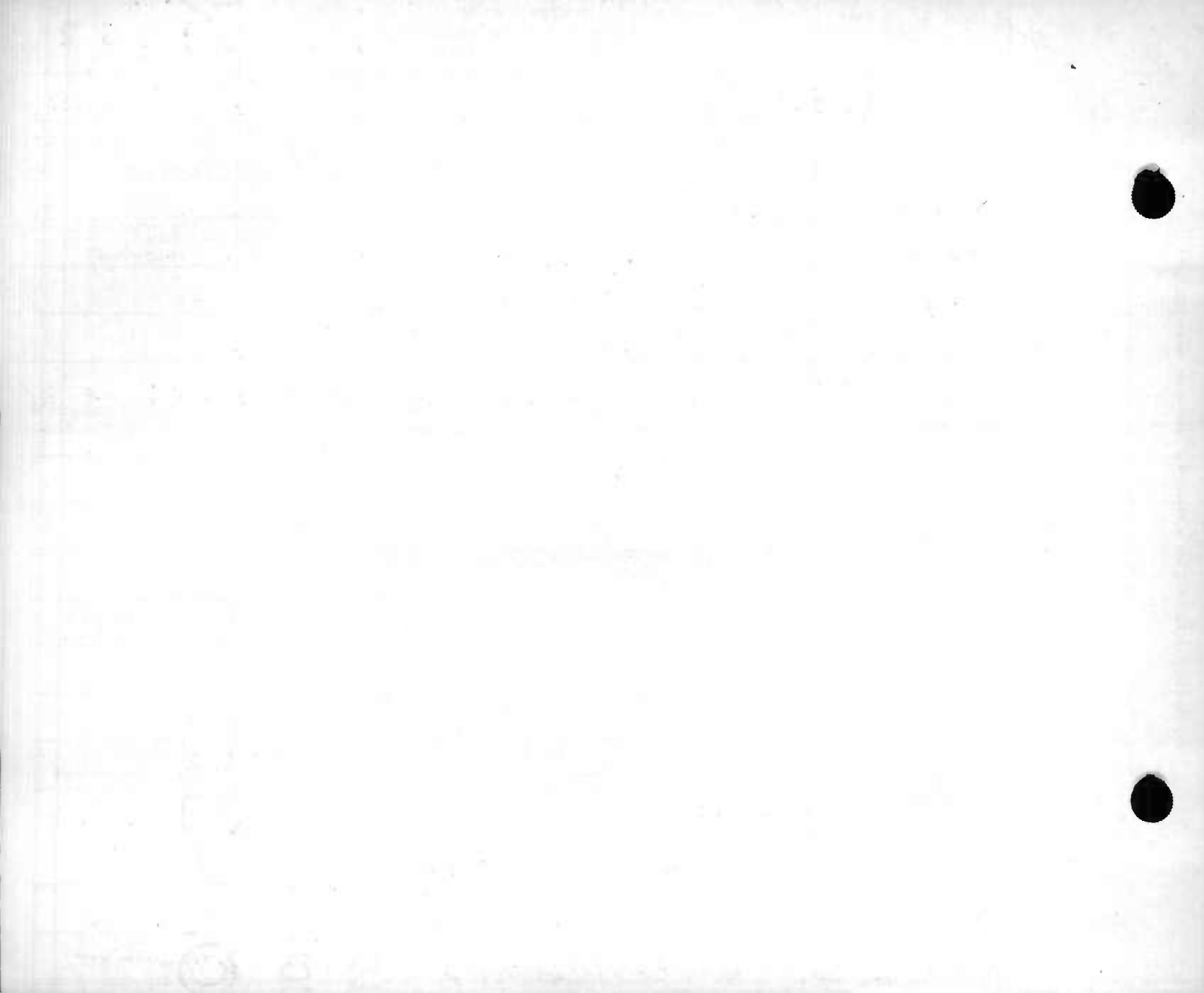


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of burial with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH																								
<div style="display: flex; justify-content: space-between;"> <div> <p>Items 18 &amp; Part 2 G538 1/3/80</p> <p>FOR dad</p> <p>1 - STATE REGISTRAR</p> </div> <div> <p>7 9 3 0 2 5 2</p> <p>REG. NO.</p> </div> </div>																								
1. DECEASED NAME (TYPE OR PRINT)					2a. DATE OF DEATH		MONTH		DAY		YEAR		2b. HOUR											
NICELY (Nicey) JONES					12		5		79		2:08A		M											
3. SEX			4. RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			7. IF UNDER 1 YEAR			8. IF UNDER 24 HRS										
F			B		11 02 92			87			YRS			MONTHS										
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION		12a. USUAL OCCUPATION			12b. KIND OF BUSINESS OR INDUSTRY			13. STREET ADDRESS			14. FATHER'S NAME										
BALTO.			South Baltimore General		Retired			Factory			1213 Light St.			AARON										
15. MOTHER'S MAIDEN NAME					16a. WAS DECEASED EVER IN U.S. ARMED FORCES?					16b. SOCIAL SECURITY NO.					17. INFORMANT									
CASSIE					NO					25-07-0184					DORIS CLASH 713 5th Ver Creek Rd									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)															APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
PART I. DEATH WAS CAUSED BY:																								
7070 IMMEDIATE CAUSE (a) Sepsis																								
DUE TO, OR AS A CONSEQUENCE OF																								
Decubitus ulcers																								
DUE TO, OR AS A CONSEQUENCE OF																								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):																								
Upper G I bleeding, hypoglycemic coma																								
19a. DATE OF OPERATION					19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY?					20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?									
										YES <input type="checkbox"/> NO <input type="checkbox"/>					YES <input type="checkbox"/> NO <input type="checkbox"/>									
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					21b. TIME OF INJURY					21c. HOW INJURY OCCURRED														
					HOUR A.M. MONTH DAY YEAR					ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2														
21d. INJURY OCCURRED					21e. PLACE OF INJURY					21f. LOCATION														
WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK					(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)					CITY OR TOWN					COUNTY STATE									
22a. I certify that (I) (this hospital) attended the deceased from 12/3 1979 to 12/5 1979, that (I) (we) lost saw the deceased alive on 12/5 1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																								
22b. SIGNATURE										DEGREE					22c. DATE SIGNED									
Steven Rapp															12/5/79									
22d. PHYSICIAN'S NAME (TYPE OR PRINT)										22e. ADDRESS														
STEVEN RAPP										3001 S HANOVER ST														
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)					23b. DATE					23c. NAME OF CEMETERY OR CREMATORY					23d. LOCATION									
BURIAL					12-10-79					MT. Auburn Cem					BALTO COUNTY MD									
24. FUNERAL DIRECTOR										25a. DATE REC'D. BY REGISTRAR					25b. REGISTRAR'S SIGNATURE									
L. BROOK + SEN P.A. 1913 W. BALLOST										6 1979					L. Brody									



DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

79 30253

1- FOR  
STATE  
REGISTRAR

1 DECEASED NAME (TYPE OR PRINT) <b>Robert</b>			FIRST MIDDLE LAST <b>Jones, Jr.</b>			2a DATE OF DEATH MONTH DAY YEAR <b>12/7/79</b>			2b HOUR <b>11:20</b> AM		
3 SEX <b>Male</b>			4 RACE <b>Negro</b>			5 DATE OF BIRTH MONTH DAY YEAR <b>4 15 35</b>			6 AGE (IN YEARS LAST BIRTHDAY) <b>44</b> YRS		
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Balto., Md.</b>			7b CITIZEN OF WHAT COUNTRY? <b>USA</b>			8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.		
10 CITY OR TOWN OF DEATH <b>Baltimore</b>			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Lutheran Hospital Of Maryland</b>			12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b KIND OF BUSINESS OR INDUSTRY		
13a STATE <b>Md.</b>			13b COUNTY <b>Baltimore</b>			13c CITY OR TOWN <b>Baltimore</b>			13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14 FATHER'S NAME FIRST MIDDLE LAST <b>Robert Jones, Sr.</b>			15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Rose Wells</b>			16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>			16b SOCIAL SECURITY NO. <b>213-30-6263</b>		
17 INFORMANT ADDRESS <b>Martha Jones 1707 W. North Avenue</b>											

## MEDICAL CERTIFICATION

18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute myocardial infarction</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>minutes</b>	
410- Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		(b) <b>Chronic congestive heart failure with shock</b> hour	
		(c) <b>Massive coronary heart disease.</b> month	

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):  
**Urinary tract infection**

19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b> P.M.		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE			
22a I certify that (I) (this hospital) attended the deceased from <b>10-14</b> , 19 <b>79</b> , to <b>12-7</b> , 19 <b>79</b> , that (I) (we) lost saw the deceased alive on <b>12-7</b> , 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b SIGNATURE <b>Sujeta Sapsiri</b> DEGREE <b>B.S.</b>				ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c DATE SIGNED <b>12-7-79</b>	
22d PHYSICIAN'S NAME (TYPE OR PRINT) <b>SUJETA SAPSIRI</b>				22e ADDRESS <b>Lutheran Hospital of Maryland</b>			

23a BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b DATE <b>12/10/79</b>		23c NAME OF CEMETERY OR CREMATORY <b>Md. Nat. Mem. Pl.</b>		23d LOCATION CITY OR TOWN COUNTY STATE <b>Laurel, Maryland</b>	
24 FUNERAL DIRECTOR NAME <b>Wm. C. March Funeral Hm./1101 E. North Ave.</b>				25a DATE REC'D. BY REGISTRAR <b>DEC 10 1979</b>		25b REGISTRAR'S SIGNATURE <b>Richard M. Brady</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



DEC 10 1979



FOR  
1 - STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO. 9 3 0 2 5 4

1. DECEASED NAME (TYPE OR PRINT) <b>SAMUEL A. E. JONES</b>			2a. DATE OF DEATH MONTH <b>12</b> DAY <b>19</b> YEAR <b>79</b>		2b. HOUR <b>1:45 PM</b>
3. SEX <b>MALE</b>	4. RACE <b>BLACK</b>	5. DATE OF BIRTH MONTH <b>7</b> DAY <b>4</b> YEAR <b>41</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>38</b> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MARYLAND</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTO CITY</b> MD.	
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Samaritan Hosp</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>B. GREEN CO.</b>	12b. KIND OF BUSINESS OR INDUSTRY
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) <b>MD</b>			13b. COUNTY <b>Hart</b>	13c. CITY OR TOWN <b>Edgewood</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST <b>Charles</b> MIDDLE <b>Cummins</b> LAST <b>Jones</b>		15. MOTHER'S MAIDEN NAME FIRST <b>Dorothy</b> MIDDLE <b>Jones</b> LAST <b>Jones</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>217-38-2281</b>		17. INFORMANT <b>Charles Jones</b> ADDRESS <b>3448 Park Hghts.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>HYPOXIC ENCEPHALOPATHY S/P cardio-</b> <b>7070</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF <b>Pulmonary arrest.</b> b. <b>Pneumonia and Emphysema.</b> DUE TO, OR AS A CONSEQUENCE OF <b>cardiomyopathy</b> c. <b>Bilateral Decubiti</b>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. <b>Flexion contractures, anemia, SIADH, Poor Nutritional Status.</b>					
19a. DATE OF OPERATION <b>2</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>9-6-1979</b> to <b>12-19-1979</b> , that (I) (we) last saw the deceased alive on <b>12-19-1979</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>M. N. Khan</b>		DEGREE <b>MD.</b>		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>KHAN</b>		22e. ADDRESS <b>6625 Wycombe Way Balto. Md. 21234</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>12/22/1979</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Arbutus Mem. Park</b>	
23d. LOCATION CITY OR TOWN <b>Arbutus, Maryland</b>		23e. COUNTY <b>Maryland</b>		23f. STATE	
24. FUNERAL DIRECTOR OR NAME <b>William C. March</b>		24b. ADDRESS <b>4101 EAST NORTH AVE</b>		25a. DATE REC'D. BY REGISTRAR <b>DEC 20 1979</b>	
25b. REGISTRAR'S SIGNATURE <b>Barbara McCreedy</b>					

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of 4.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.



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MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		7 9 3 0 2 5 5		REG. NO.					
1. DECEASED NAME (TYPE OR PRINT) OLAV JORGENSEN				2a. DATE OF DEATH 12 14 79		6. HOUR 12 AM			
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH 2 16 1901		6. AGE (IN YEARS LAST BIRTHDAY) 78		8. UNDER 1 YEAR MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) NORWAY		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.			
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) ST. AGNES HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) RIGGER		12b. KIND OF BUSINESS OR INDUSTRY BETH. STEEL			
13a. STATE MARYLAND		13b. COUNTY BALTIMORE		13c. CITY OR TOWN BALTIMORE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 2817 PENNSYLVANIA AVENUE	
14. FATHER'S NAME UNKNOWN JORGENSEN				15. MOTHER'S MAIDEN NAME UNKNOWN					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 215-07-4184		17. INFORMANT ADDRESS ROSE JORGENSEN 2817 PENNSYLVANIA AVENUE					
11. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiopulmonary arrest</u> 410- DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) <u>Acute inferior myocardial infarct</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Complete heart block</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION CITY OR TOWN COUNTY STATE					
22. I certify that (I) (this hospital) attended the deceased from <u>12/13/79</u> to <u>12/14/79</u> , that (I) (we) lost above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>Cyunt</u>				DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 12/14/79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) KYAW NYUNT				22e. ADDRESS 900 CATON AVE. BALTIMORE, MD. 21229					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 12/17/79		23c. NAME OF CEMETERY OR CREMATORY MEADOWRIDGE MEM. PARK		23d. LOCATION CITY OR TOWN COUNTY STATE EKLIDGE HOWARD MARYLAND			
24. FUNERAL DIRECTOR HUBBARD FUNERAL HOMER 4107 WILKENS AVE				25. DATE REC'D. BY REGISTRAR DEC 17 1979		25b. REGISTRAR'S SIGNATURE <u>Henry McCreedy</u>			

BALTIMORE CITY

ST. JAMES HOSPITAL

BALTIMORE

JOHN J. HENNING

RECEIVED

NEW

ALBANY, N.Y.

1000 BALTIMORE AVE. BALTIMORE, MD. 21202

ALBANY

DEPT. OF HEALTH

ALBANY, N.Y.

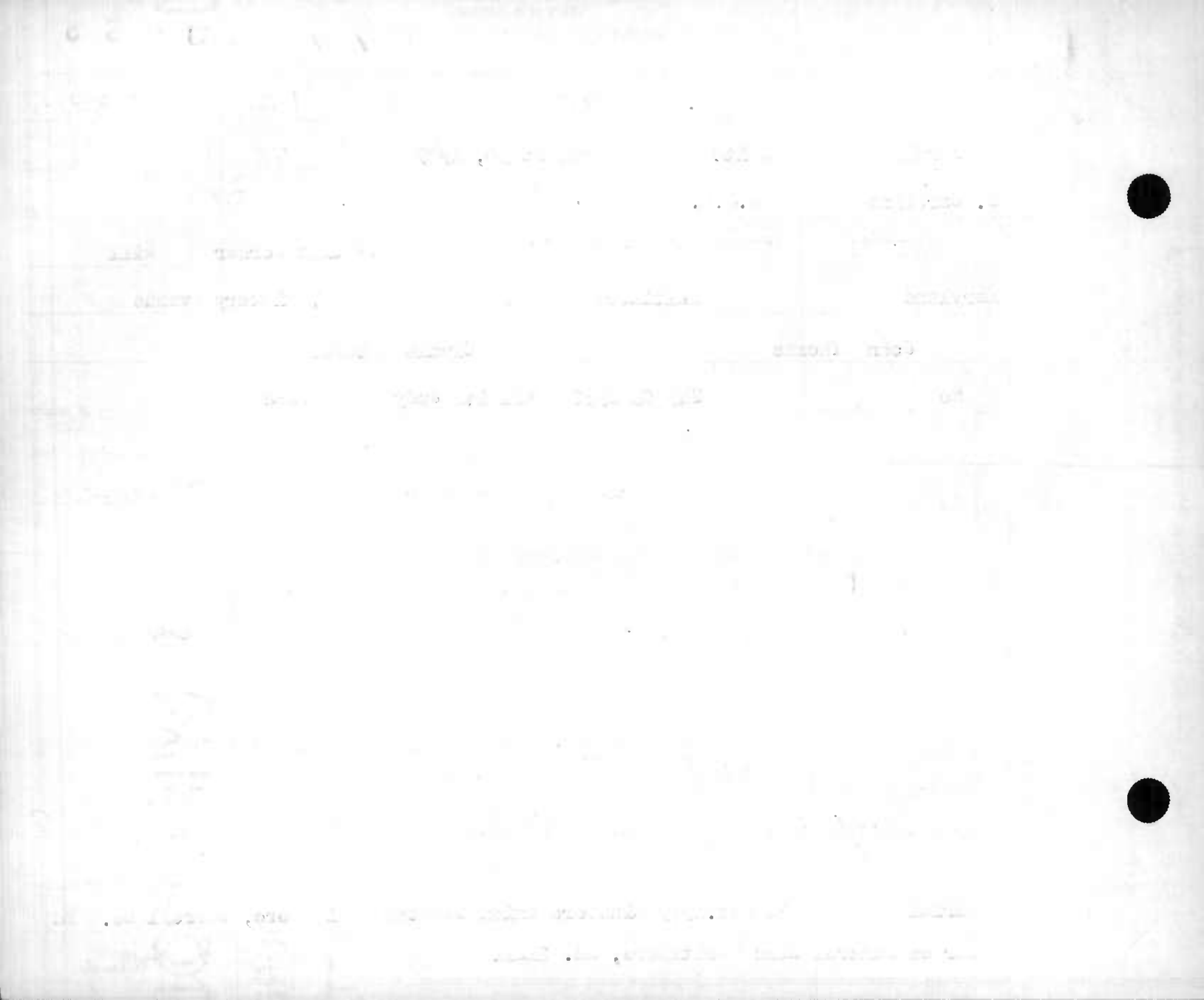


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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				7 9 3 0 2 5 6			
1. FOR STATE REGISTRAR				CERTIFICATE OF DEATH			
1. DECEASED NAME (TYPE OR PRINT)				2a. DATE OF DEATH			
ETTA B. JUDY				MONTH DAY YEAR			
3. SEX				4. RACE			
Female				White			
5. DATE OF BIRTH				6. AGE (IN YEARS LAST BIRTHDAY)			
MONTH DAY YEAR				MONTHS DAYS HOURS MIN			
August 30, 1909				70 YRS			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)				7b. CITIZEN OF WHAT COUNTRY?			
S. Carolina				U.S.A.			
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH			
				BALTIMORE CITY MD.			
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION			
BALTIMORE				UNION MEMORIAL HOSPITAL			
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY			
Textile Worker				Mill			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				13b. COUNTY			
13a. STATE				13b. CITY OR TOWN			
Maryland				Baltimore			
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME			
FIRST MIDDLE LAST				FIRST MIDDLE LAST			
John Thomas				Clydia Stokes			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)				16b. SOCIAL SECURITY NO.			
No				249 01 6552			
17. INFORMANT				ADDRESS			
William Judy				Same			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)							
PART I. DEATH WAS CAUSED BY							
IMMEDIATE CAUSE (a) CHF							
4149 DUE TO, OR AS A CONSEQUENCE OF							
(b) ASCVD / Ischemic Heart Disease							
DUE TO, OR AS A CONSEQUENCE OF							
(c)							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
ASCVD, Renal insufficiency, Anemia							
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			
12/18/79				Thrombosed & profunda			
20a. AUTOPSY?				20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY			
				HOUR A.M. MONTH DAY YEAR			
				P.M. 19			
21d. INJURY OCCURRED				21e. PLACE OF INJURY			
WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>				(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			
				21f. LOCATION			
				STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 12/18, 19 79, to 12/27, 19 79, that (I) (we) last saw the deceased alive on 12/18, 19 79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE				DEGREE			
D. Berline				MD			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS			
D. Berline				Union Memorial Hosp.			
23a. BURIAL, CREMATION, REMOVAL				23b. DATE			
Burial				31 Dec. 1979			
23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION			
Lineboro Union Cemetery				CITY OR TOWN COUNTY STATE			
				Lineboro, Carroll Co. Md			
24. FUNERAL DIRECTOR				25a. DATE REC'D. BY REGISTRAR			
Burgee Funeral Home Baltimore, Md. 21211				25b. REGISTRAR'S SIGNATURE			
				DEC 31 1979			



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

7 9 30257

REG. NO.

1. FOR STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT)		FIRST Bettie	MIDDLE	LAST Julian	2a. DATE OF DEATH	MONTH 12	DAY 27	YEAR 79	2b. HOUR 9:35 PM
3. SEX Female	4. RACE Black	5. DATE OF BIRTH		MONTH 3	DAY 31	YEAR 11	6. AGE (IN YEARS LAST BIRTHDAY)	YRS. 68 YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) North Carolina	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.							
10. CITY OR TOWN OF DEATH Baltimore	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) MIEHSS				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife				12b. KIND OF BUSINESS OR INDUSTRY		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE Md.		13b. COUNTY Balto		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS Julianwood Rd.			
14. FATHER'S NAME FIRST MIDDLE LAST Halley H. Taylor						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Marie Ravenmah					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. 21982 7246		17. INFORMANT ADDRESS Dr. James S. Julian Julianwood Rd.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Septis</u> <u>1533</u> DUE TO, OR AS A CONSEQUENCE OF: (b) <u>Perforated Cecum</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) <u>Concomitant sigmoid colon</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>3 days</u> <u>more than 2 wks.</u>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Hypertension</u>											
19a. DATE OF OPERATION <u>11-29-79</u>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Bowel obstruction + perforation</u>				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <u>11-28</u> , 19 <u>79</u> , to <u>12-2</u> , 19 <u>79</u> , tho (I) (we) last saw the deceased alive on <u>12-2</u> , 19 <u>79</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.											
22b. SIGNATURE <u>Charles E. Wiles III</u>		DEGREE MD		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c. DATE SIGNED <u>12-2-79</u>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Charles E. Wiles III</u>		22e. ADDRESS <u>MIEHSS 225 Greene St. Balto. Md.</u>									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		23b. DATE <u>12/7/79</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Arbutus</u>		23d. LOCATION CITY OR TOWN COUNTY STATE <u>Balto. Md.</u>					
24. FUNERAL DIRECTOR NAME <u>Jas. A. Morton &amp; Sons 1701 Laurens St.</u>						25a. DATE REC'D. BY REGISTRAR <u>DEC 4 1979</u>		25b. REGISTRAR'S SIGNATURE <u>Rafay McHenry</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

Housewife  
Luttrell Rd.

Reverend

Maria

Valley F. Taylor

Dr. James E. Butler  
Luttrell Rd.

Palto

Arborea

12/7/79

Enrich

Jan. A. Norton & Sons 1701 Laurens St.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 50M 1/76  
(VR A 15 (4))

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST <b>ALVERTA M. JUSKELIS</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>12/24/79</b>			2b. HOUR <b>1:25 P.M.</b>		
3. SEX <b>FEMALE</b>			4. RACE <b>White CAUCASIAN</b>			5. DATE OF BIRTH MONTH DAY YEAR <b>11/20/1910</b>			6. AGE (IN YEARS LAST BIRTHDAY) <b>69</b> YRS.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Md., Baltimore</b>			7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City, MD.</b>		
10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Good Samaritan Hospital</b>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Saleslady</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>Dept. Store</b>		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE COUNTY <b>MD Baltimore</b>			13c. CITY OR TOWN <b>Balto</b>			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS <b>359, WHITFIELD RD</b>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>Michael Stavis</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Mary ?</b>			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>No</b>			16b. SOCIAL SECURITY NO. <b>218-03-2367</b>		
17. INFORMANT <b>Baltimore, Md. 21207.</b>			17. INFORMANT <b>Mrs. Mary F. Sikora-8239 Vosges Road</b>			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>metastatic Adenocarcinoma - unknown primary</b> 1991 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____ DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>11/14/79</b> to <b>12/24/79</b> , that (I) (we) lost the deceased on <b>12/24/79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>N. Zagloma</b>			DEGREE <b>MD</b>			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			22c. DATE SIGNED <b>12/24/79</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>N. ZAGLAMA</b>			22e. ADDRESS <b>Good Samaritan Hosp</b>								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>12/28/79</b>			23c. NAME OF CEMETERY OR CREMATORY <b>New Cathedral Cemetery</b>			23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore, Md.</b>		
24. FUNERAL DIRECTOR NAME <b>Sterling Funeral Estate</b>			ADDRESS <b>736 Edmondson Ave. Catonsville Md 21229</b>			25a. DATE REC'D. BY REGISTRAR <b>DEC 31 1979</b>			25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>		

BP





DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MD. 21201

BP  
DHMH - 17  
IVR A15 ME (1)  
15M 7/76

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

Items #10a-22a Film G541 3/3/80 STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										30259 REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) <b>HENRY Flory alias Sokrates Kamtsios</b>						2a. DATE KNOWN OF DEATH ESTIMATED <b>12 12 19 79</b>		2b. HOUR <b>3:00 P</b>			
3. SEX <b>male</b>		4. RACE <b>white</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>July 15 1906</b>		6. AGE (IN YEARS) LAST BIRTHDAY <b>73 YRS.</b>		7c. DATE PRONOUNCED DEAD MONTH DAY YEAR <b>12 12 19 79</b>			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Greece</b>		7b. CITIZEN OF WHAT COUNTRY? <b>Greece</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.					
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION <b>Police Boat Dock 4-400blk.Pratt St.</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Restaurant Business</b>		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE <b>Md</b>				13b. CITY OR TOWN <b>Baltimore</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>--</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>- Kamtsios</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>-</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) IF YES, GIVE WAR OR DATES <b>no</b>				16b. SOCIAL SECURITY NO. <b>890-90-5116</b>		17. INFORMANT ADDRESS <b>Mr. Nicholas Kerasiotes 1110 Cowpens Rd. 21204</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: <b>984- Drowning</b> IMMEDIATE CAUSE (a) <b>Drowning</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>? P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) <b>subject fell into water</b>					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <b>Police boat dock</b>		21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b>400 Blk, E. Pratt St. Baltimore Md.</b>					
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/> .											
ACTUAL SIGNATURE <b>Margareta Korell</b>				TITLE (SPECIFY) <b>Assistant</b>				DATE SIGNED <b>12/13/79</b>			
EXAMINER'S NAME (TYPE OR PRINT) <b>Margarita A. Korell, M.D.</b>				ADDRESS <b>111 Penn Street</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>				23b. DATE <b>Dec. 19, 1979</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Greek Ortho. Cem.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Woodlawn Balw. Md</b>			
24. FUNERAL DIRECTOR NAME ADDRESS <b>Leonard J. Ruck Inc. Baltimore, Maryland</b>						25a. DATE REC'D. BY REGISTRAR <b>DEC 20 1979</b>		25b. REGISTRAR'S SIGNATURE <b>Anthony McBrady</b>			

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FOR  
1 - STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO. 7 9 3 0 2 6 0

1. DECEASED NAME (TYPE OR PRINT) <b>Mary Eileen Kane</b>			2a. DATE OF DEATH MONTH <b>12</b> DAY <b>11</b> YEAR <b>79</b>			2b. HOUR <b>9:57P</b> M			
3 SEX <b>Female</b>		4 RACE <b>White</b>		5. DATE OF BIRTH MONTH <b>Nov.</b> DAY <b>6,</b> YEAR <b>1921</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>58</b> YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Baltimore, Md.</b>		7b CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.			
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Mercy Hospital</b>				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Security-Guard</b>		12b KIND OF BUSINESS OR INDUSTRY <b>Detect. Agcy.</b>	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Md.</b> 13b. COUNTY <b>----</b> 13c. CITY OR TOWN <b>Baltimore</b> 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> 13e. STREET ADDRESS <b>3510 E. Baltimore Street</b>									
14 FATHER'S NAME FIRST <b>John</b> MIDDLE <b>P.</b> LAST <b>Meehan</b>					15. MOTHER'S MAIDEN NAME FIRST <b>Mary</b> MIDDLE <b>B.</b> LAST <b>McGuinness</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b>		16b. SOCIAL SECURITY NO. <b>WW II</b>		17 INFORMANT <b>Baltimore, Md. 21224.</b> <b>John C. Kane-3510 E. Baltimore St.</b>					
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>SEPSIS</b> <b>436-</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>URINARY TRACT INFECTION</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>CEREBROVASCULAR ACCIDENT</b>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>12/10</b> 19 <b>79</b> , to <b>12/11</b> 19 <b>79</b> , that (I) (we) lost saw the deceased alive on <b>12/11</b> 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>Stephen K. Dyal</b>					DEGREE <b>MD</b>		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>12/10/79</b>
22d. PHYSICIAN'S NAME (TYPE OR PRINT)					22e. ADDRESS				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>12/14/79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>New Cathedral Cemetery</b>		23d. LOCATION CITY OR TOWN <b>Baltimore, Md.</b> COUNTY STATE		
24. FUNERAL DIRECTOR NAME <b>John A. Moran, Inc.</b> ADDRESS <b>3000 E. Baltimore St.</b>					25a. DATE REC'D. BY REGISTRAR <b>DEC 17 1979</b>		25b. REGISTRAR'S SIGNATURE <b>Ray...</b>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



Miss Allen

White

Female

Address, No. 1111

Age

Occupation

Married

Single

Yes

No

DEC 19 1950

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING," IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM-PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DMMH-17  
(VIR A15 ME (5))  
15M 7/76

DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 3 0 2 6 1	
1. DECEASED NAME (TYPE OR PRINT) <b>James Kasakitis</b>						20. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR <b>12 28 19 79</b>		21. HOUR <b>M</b>			
3. SEX <b>Male</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>Aug. 31, 1952</b>	6. AGE (IN YEARS) LAST BIRTHDAY <b>27 YRS.</b>	IF UNDER 1 YR. MONTHS DAYS <b>0 0</b>	IF UNDER 24 HRS. HOURS MIN. <b>0 0</b>	22. DATE PRONOUNCED DEAD MONTH DAY YEAR <b>12 28 19 79</b>		23. HOUR <b>10:43A</b>			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Penna.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City, MD.</b>					
10. CITY OR TOWN OF DEATH <b>Baltimore City</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>South Baltimore General Hosp.</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Clerk</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>railroad</b>			
13a. STATE <b>Maryland</b>				13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Lansdowne</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>Theodore Kasakitis</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Leona Ketusky</b>		16. SOCIAL SECURITY NO. <b>219-54-4346</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>no</b>				16b. SOCIAL SECURITY NO. <b>219-54-4346</b>		17. INFORMANT <b>Theodore Kasakitis</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute myocardial infarction</b> <b>410-</b> Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: <b>Natural causes</b> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE <b>Thomas D. Smith</b>				TITLE (SPECIFY) <b>Deputy Chief</b>				DATE SIGNED <b>12/28/79</b>			
EXAMINER'S NAME (TYPE OR PRINT) <b>Thomas D. Smith, M.D.</b>				ADDRESS <b>111 Penn St. Balto., MD.</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>burial</b>		23b. DATE <b>12/31/79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Meadowridge Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Dorsey Maryland</b>					
24. FUNERAL DIRECTOR NAME <b>Ambrose Funeral Home</b>				ADDRESS <b>1328 Sulphur Spring Rd.</b>		25a. DATE REC'D. BY REGISTRAR <b>DEC 31 1979</b>		25b. SIGNATURE <b>Howard</b>			

141.

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13. 11. 1

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PA 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										RECORD NO. 3 0 2 6 2	
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE KNOWN OF DEATH		2b. HOUR	
Stanley		W.		Keaton				2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> 12 15 19 79		2b. HOUR 9:35 a. M.	
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS)	IF UNDER 1 YR.		IF UNDER 24 HRS.		2c. DATE PRONOUNCED DEAD		2d. HOUR
male	black	8/5/43		36 YRS.					12 15 19 79		a. M.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
Maryland		U.S.A.				Baltimore City MD.					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
Baltimore		Sinai Hospital				House Keeper		Univ. Hos.			
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS			
Md		City		Balto.		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		4629 Lanier Ave.			
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME							
FIRST MIDDLE LAST				FIRST MIDDLE LAST							
James Griffin				Gladys Keaton							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS					
Yes		Vietnam		212-42-1288		Gladys Keaton 4629 Lanier Ave.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY:										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease											
DUE TO, OR AS A CONSEQUENCE OF											
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.											
(b)											
DUE TO, OR AS A CONSEQUENCE OF											
(c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):											
Acute ethanol intoxication											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY?	
										YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
				P.M. 19							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION					
						CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE				TITLE (SPECIFY)				DATE SIGNED			
Hormez R. Guard, M.D.				M.D. Assistant MEDICAL EXAMINER				12/15/79			
EXAMINER'S NAME (TYPE OR PRINT)				ADDRESS							
Hormez R. Guard, M.D.				111 Penn Street, Balto., MD 21201							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION					
Burial		12/20/79		Md. Veterans Cem.		Cheltenham P.G. Md.					
24. FUNERAL DIRECTOR						25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
NAME Charles A. Rice ADDRESS 1300 Eutaw Place						DEC 21 1979		[Signature]			

Charles A. Rice 1800 Keweenaw Place

DEPT 101

Special

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed within 72 hours at the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1- FOR STATE REGISTRAR		7 9 3 0 2 6 3				REG. NO.			
1 DECEASED NAME (TYPE OR PRINT)		Christina Kay KEENEY				2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR	
BABY GIRL		11 29 79				DECEMBER 1, 1979		04:15PM	
3 SEX		4 RACE		5 DATE OF BIRTH MONTH DAY YEAR		6 AGE (IN YEARS LAST BIRTHDAY)		7 UNDER 1 YEAR MONTHS DAYS	
Female		White		11 29 79		YRS. 2		HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH			
Maryland		U.S.A.				BALTIMORE CITY MD			
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Baltimore City		THE JOHNS HOPKINS HOSPITAL				none		none	
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13a. STREET ADDRESS	
Maryland		Carroll		New Windsor		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		1626 Dennings Rd.	
14 FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST							
George T. Keeney		Grace Baumgardner							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17 INFORMANT ADDRESS					
No		none		George T. Keeney New Windsor, Md.					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cardio Respiratory Arrest</u>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
7597 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Multiple congenital anomalies</u>									
DUE TO, OR AS A CONSEQUENCE OF (c) <u></u>									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
		P.M. 19							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22 I certify that (I) (this hospital) attended the deceased from <u>11/29</u> 19 <u>79</u> , to <u>12/1</u> 19 <u>79</u> , that (I) (we) lost saw the deceased alive on <u>12/1</u> 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE		DEGREE				ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED	
<u>D. W. Hartman</u>		MD						Dec 1 79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS							
<u>D. W. Hartman</u>		<u>Johns Hopkins Hospital</u>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE			
Burial		12/4/79		St. James Cemetery		New Windsor Carroll Md.			
24 FUNERAL DIRECTOR (NAME)		24b. ADDRESS				25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE			
<u>D. W. Hartman</u>		<u>New Windsor, Md.</u>				<u>DEC 6 1979</u>			



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon-copy. Pages 1 and 3 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				7 9 3 0 2 6 4 REG. NO.				
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Bernard Kegan</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>December 29, 1979</b>				2b. HOUR M
3. SEX <b>Male</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>Sept 13, 1930</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>49</b> YRS		7. UNDER 1 YEAR MONTHS DAYS 8. UNDER 24 HRS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Md.</b>	7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>City</b> MD.				
10. CITY OR TOWN OF DEATH <b>Baltimore</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>1262 Limit Avenue</b>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Koppers Co. Analysis</b>		12b. KIND OF BUSINESS OR INDUSTRY		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				13a. STREET ADDRESS <b>1262 Limit Avenue</b>				
13a. STATE <b>Md.</b>	13b. COUNTY	13c. CITY OR TOWN <b>Baltimore</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS		
14. FATHER'S NAME FIRST MIDDLE LAST <b>Edward B. Kegan</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Mildred Mueller</b>		16. ADDRESS				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>yes</b>		16b. SOCIAL SECURITY NO. <b>213-26-0622</b>		17. INFORMANT <b>Mrs. Rose Marie R. Kegan same</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardio Respiratory Failure</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Abdominal &amp; Liver Carcinomatosis</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Adenocarcinoma of Colon</b> 1539							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 day</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Colon Resection</b>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <b>July</b> , 19 <b>79</b> to <b>Dec. 30</b> , 19 <b>79</b> , that (I) (we) last saw the deceased alive on <b>Dec 30</b> , 19 <b>79</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE <b>W B Rever Jr.</b>		DEGREE <b>M.D.</b>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>12/31/79</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>William R. Rever Jr., MD</b>		22e. ADDRESS <b>801 Providence Road Balto. Md. 21204</b>						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>Jan. 2, 1980</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Loudon Park</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore Md.</b>		
24. FUNERAL DIRECTOR NAME <b>Leonard J. Ruck Inc. Baltimore, Maryland</b>		ADDRESS		25a. DATE REC'D. BY REGISTRAR <b>JAN 3 1980</b>		25b. REGISTRAR'S SIGNATURE <b>Jeffrey Helmsky</b>		



4-20



Handwritten text, mostly illegible due to fading and bleed-through. The text appears to be organized into several paragraphs or sections, possibly containing dates and names. Some legible fragments include "April 20", "1911", and "Chicago".

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL HOME. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 3 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG 30 0 2 6 5	
1. DECEASED NAME (TYPE OR PRINT) <b>KAREEM KEITH</b>						2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH <input type="checkbox"/> DAY <input type="checkbox"/> YEAR <b>12 21 79</b>		2b. HOUR <b>6:22 P</b>			
3. SEX <b>male</b>	4. RACE <b>black</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>7 5 73</b>	6. AGE (IN YEARS) LAST BIRTHDAY <b>6 YRS.</b>	IF UNDER 1 YR. MONTHS DAYS <b>0 0</b>	IF UNDER 24 HRS. HOURS MIN <b>0 0</b>	2c. DATE PRONOUNCED DEAD MONTH DAY YEAR <b>12 21 79</b>		2d. HOUR <b>P</b>			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>US</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.					
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Sinai Hospital</b>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>STUDENT</b>		12b. KIND OF BUSINESS OR INDUSTRY				
13a. STATE <b>MARYLAND</b>			13b. COUNTY		13c. CITY OR TOWN <b>BALTIMORE</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
14. FATHER'S NAME FIRST MIDDLE LAST <b>VERNON KEITH</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>JESSIE WELLS</b>			13e. STREET ADDRESS <b>2644 GATEHOUSE DRIVE</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)			16b. SOCIAL SECURITY NO. <b>NONE</b>		17. INFORMANT ADDRESS <b>JESSIE WELLS 2644 GATEHOUSE DRIVE</b>						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cranip-cerebral injury</b> Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR MONTH DAY YEAR <b>5:45 P.M. 12-21 79</b>		21c. HOW INJURY OCCURRED (NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) <b>auto in passenger in/which a driver lost control</b>						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <b>street/northbound</b>		21f. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore, Maryland</b>						
22a. I certify that I took charge of the remains described above, held on death resulted from: <b>Natural causes</b> <input type="checkbox"/> <b>Accident</b> <input checked="" type="checkbox"/> <b>Autopsy</b> <input type="checkbox"/> <b>Inspection</b> <input checked="" type="checkbox"/> <b>Inquiry</b> <input type="checkbox"/> and in my opinion <b>death resulted from:</b> <b>Natural causes</b> <input type="checkbox"/> <b>Accident</b> <input checked="" type="checkbox"/> <b>Autopsy</b> <input type="checkbox"/> <b>Homicide</b> <input type="checkbox"/> <b>Undetermined manner</b> <input type="checkbox"/>											
ACTUAL SIGNATURE <b>H.R. Guard</b>			TITLE (SPECIFY) <b>Assistant</b>			DATE SIGNED <b>12/22/79</b>		M.D. MEDICAL EXAMINER			
EXAMINER'S NAME (TYPE OR PRINT) <b>Hormez R. Guard, M.D.</b>			ADDRESS <b>111 Penn Street</b>								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>			23b. DATE <b>12-29-79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>ARBUTUS MEM. PK.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>BALTIMORE MARYLAND</b>				
24. FUNERAL DIRECTOR <b>PHILLIPS FUN. HOME 1721-27 N. MONROE STREET</b>					25a. DATE REC'D. BY REGISTRAR <b>DEC 28 1979</b>		25b. REGISTRAR'S SIGNATURE <b>R. H. H. H.</b>				



John Doe

John Doe

John Doe

John Doe

John Doe

John Doe

John Doe

John Doe

John Doe

John Doe

Items #10a-22a Film G540 2/8/80 STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 30266

1- STATE REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST  
VERNON KEITH

2a. DATE KNOWN OF DEATH ESTI- MATED ☒ MONTH DAY YEAR 12 26 79 2b. HOUR 5:26 P M

3. SEX male 4. RACE black 5. DATE OF BIRTH MONTH DAY YEAR 5 3 45 6. AGE (IN YEARS LAST BIRTHDAY) 34 YRS. IF UNDER 1 YR. MONTHS DAYS IF UNDER 24 HRS. HOURS MIN 7c. DATE PRONOUNCED DEAD 12 26 79

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Balto. Md. 7b. CITIZEN OF WHAT COUNTRY? USA 8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐ 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.

10. CITY OR TOWN OF DEATH Baltimore 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Union Memorial Hospital 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Bethlehem Steel 12b. KIND OF BUSINESS OR INDUSTRY Welder

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  
13a. STATE Md. 13b. COUNTY Balto 13c. CITY OR TOWN Balto 13d. INSIDE CITY LIMITS? YES ☒ NO ☐ 13e. STREET ADDRESS 1901 Gwynn Falls Pkwy

14. FATHER'S NAME FIRST MIDDLE LAST John Keith 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lizzie M. Crawford

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) yes 16b. SOCIAL SECURITY NO. 217-40-3883 17. INFORMANT ADDRESS John Keith 1901 Gwynn Falls Pkwy

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART 1 DEATH WAS CAUSED BY:  
IMMEDIATE CAUSE (a) 9800 Acute morphine intoxication  
DUE TO, OR AS A CONSEQUENCE OF  
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.  
(b) DUE TO, OR AS A CONSEQUENCE OF  
(c)

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).

MEDICAL CERTIFICATION  
19a. DATE OF OPERATION 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? 20. AUTOPSY? YES ☒ NO ☐

21a. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 12/26/79 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) Morphine overdose

21d. INJURY OCCURRED WHILE ☐ NOT WHILE ☒ AT WORK 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) ? 21f. LOCATION CITY OR TOWN COUNTY STATE ?

22a. I certify that I took charge of the remains described above, held on Autopsy ☒. Inspection ☐. Inquiry ☐. and in my opinion death resulted from: Natural causes ☐. Accident ☐. Suicide ☐. Homicide ☐. Undetermined manner ☒.

ACTUAL SIGNATURE Thomas D. Smith, M.D. TITLE (SPECIFY) Deputy Chief MEDICAL EXAMINER DATE SIGNED 12/27/79

EXAMINER'S NAME (TYPE OR PRINT) Thomas D. Smith, M.D. ADDRESS 111 Penn Street

23a. BURIAL, CREMATION, REMOVAL (ECIPY) Burial 23b. DATE 12/31/79 23c. NAME OF CEMETERY OR CREMATORY King Mem Pk. 23d. LOCATION CITY OR TOWN COUNTY STATE Randallstown Md.

24. FUNERAL DIRECTOR NAME JAS. A. MORTON ADDRESS 1701 LAURENS 25a. DATE REC'D. BY REGISTRAR DEC 31 1979 25b. REGISTRAR'S SIGNATURE [Signature]

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

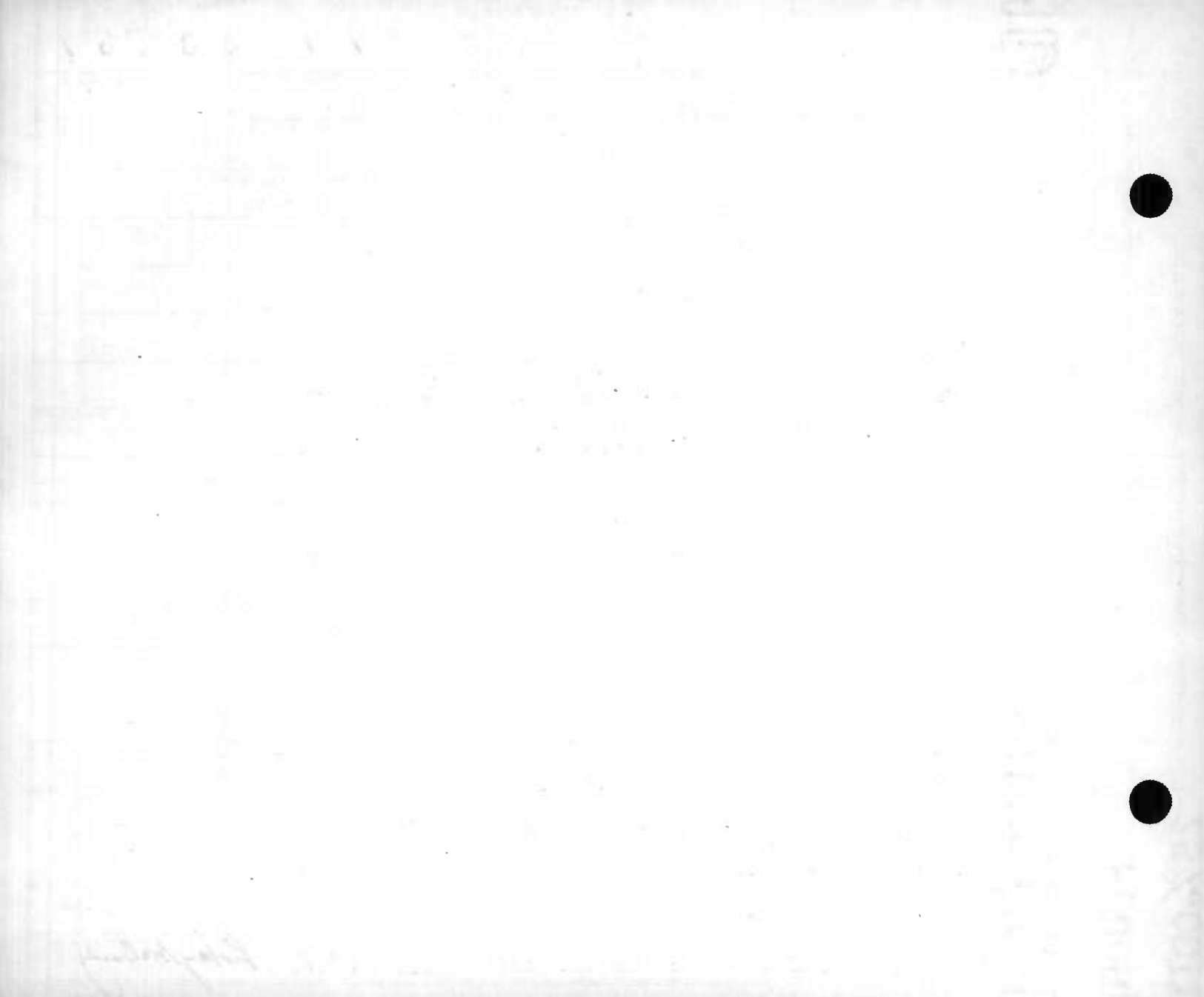
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
1- FOR STATE REGISTRAR		7 9 3 0 2 6 7		REG. NO.							
1 DECEASED NAME (TYPE OR PRINT) Charles Leslie Keller			2a DATE OF DEATH 12-13-79			2b HOUR M					
3 SEX Male		4 RACE White		5. DATE OF BIRTH Aug. 20, 1913		6 AGE (IN YEARS LAST BIRTHDAY) 66 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Baltimore City			MD.		
10 CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 4779 Shamrock Avenue				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Auto Dealer		12b. KIND OF BUSINESS OR INDUSTRY			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland			13b. COUNTY		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 4779 Shamrock Ave.		
14 FATHER'S NAME Leo Keller			15 MOTHER'S MAIDEN NAME Rose Reynolds								
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 215-09-5504		17 INFORMANT Wife: Mrs. Margaret R. Keller			ADDRESS Same address			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial infarction / Coronary</u> 1539 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)											
19a DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>Marvin Feldman</u>						DEGREE M.D.			22c. DATE SIGNED		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Marvin Feldman, M.D.						22e. ADDRESS Suite 302 Greenspring Station Falls & Joppa					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 12/17/79		23c. NAME OF CEMETERY OR CREMATORY Holy Redeemer Cemetery			23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Md.			
24 FUNERAL DIRECTOR NAME Leonard J. Ruck, Inc. 5305 Hartford Rd. 21214						25a. DATE REC'D. BY REGISTRAR DEC 14 1979		25b. REGISTRAR'S SIGNATURE <u>Henry McCreedy</u>			







1- FOR  
STATE  
REGISTRAR

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 30268

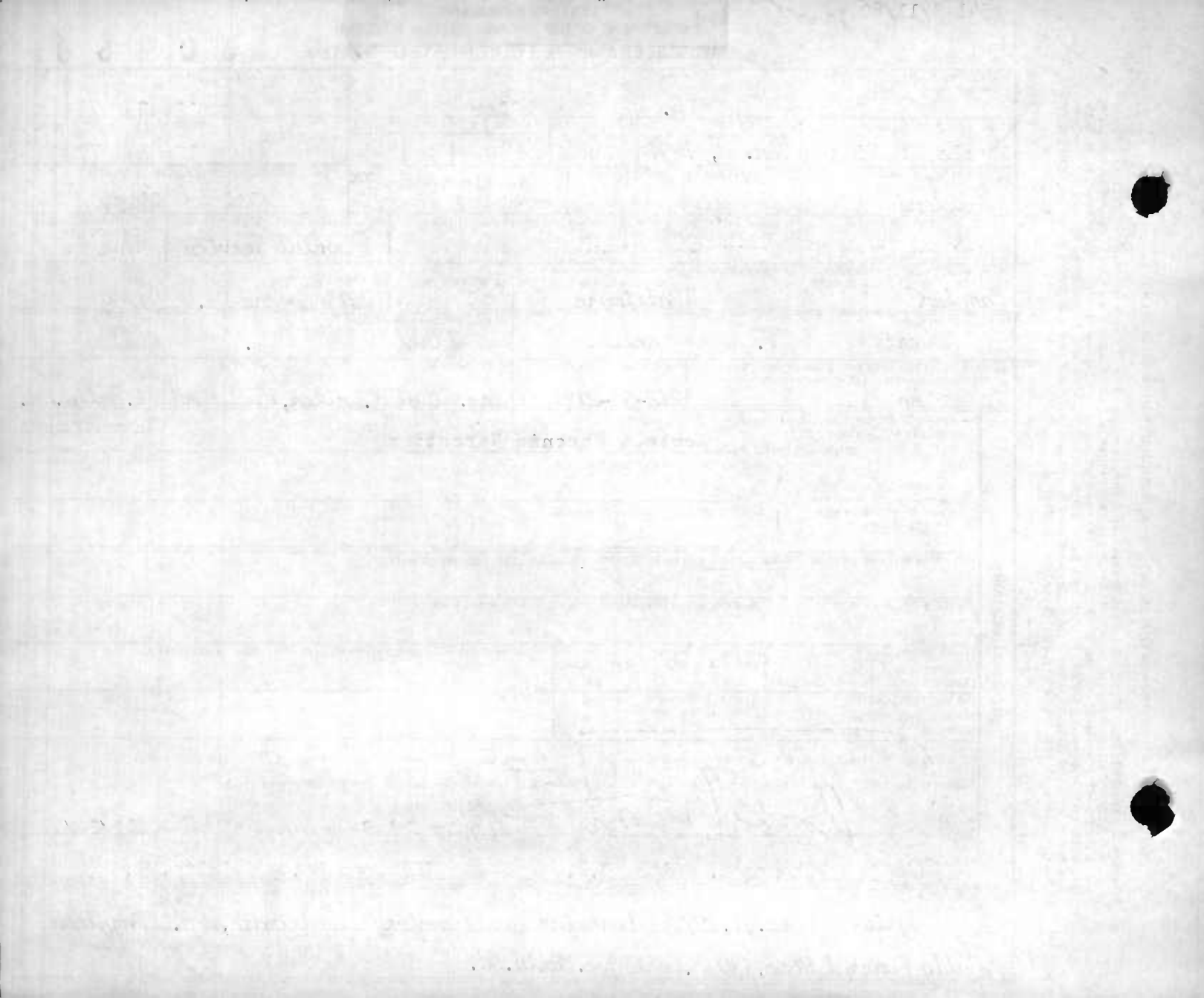
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE KNOWN OF DEATH		ESTI- MATED		MONTH		DAY		YEAR		2b. HOUR	
Rebecca		G.		Keller				12		12		27		19		79		7:14	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YR.		IF UNDER 24 HRS.		7c. DATE PRONOUNCED DEAD		MONTH		DAY		YEAR	
Female		White		Jan. 2, 1951		28 YRS.		MONTHS		DAYS		HOURS		MIN.		12		27 19 79	
BIRTHPLACE (STATE OR FOREIGN COUNTRY)				7b. CITIZEN OF WHAT COUNTRY?				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH							
Maryland				USA								Baltimore City							
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY							
Baltimore City				2215 Rogene Drive				Social Service				Worker							
13a. STATE				13b. COUNTY				13c. CITY OR TOWN				13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>				13e. STREET ADDRESS			
Maryland								Baltimore				YES				2215 Rogene Dr. 21209			
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME															
Robert				Ethel															
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)				16b. SOCIAL SECURITY NO.				17. INFORMANT ADDRESS											
No				212-58-2191				Mrs. Ethel M. Keller, 1524 Byrd St. Balto. Md.											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: 3049 IMMEDIATE CAUSE (a) Acute & Chronic Narcotism DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)																		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).																			
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?												20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE											
22a. I certify that I took charge of the remains described above, held or death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> TITLE (SPECIFY) ACTUAL SIGNATURE Deputy Chief EXAMINER'S NAME Thomas D. Smith, M.D. ADDRESS 111 Penn St., Balto, MD. 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial 23b. DATE Dec. 31, 1979 23c. NAME OF CEMETERY OR CREMATORY Lorraine Park Cemetery 23d. LOCATION City or Town Baltimore Co. Maryland 24. FUNERAL DIRECTOR NAME McFally Funeral Home, 130 E. Fort Ave. Balto. Md. 25a. DATE REC'D. BY REGISTRAR JAN 4 1980 25b. REGISTERING AGENCY																			

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY OCCURS, THE MEDICAL EXAMINER, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. RETAIN PAGES 4 AND 5 IN YOUR FILES. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGES 1 AND 2 WITHIN 72 HOURS. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 N. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

2755 BP.

DHMH - 17  
(VR A15 ME (5))  
15M 7/76



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										7 9 3 0 2 6 9	
1. FOR STATE REGISTRAR		REG. NO.									
1. DECEASED NAME (TYPE OR PRINT)		FIRST RAYMOND		MIDDLE KELLY		LAST SA		2a. DATE OF DEATH MONTH DAY YEAR 12-22-79		2b. HOUR 4:35 M	
3. SEX M		4. RACE B		5. DATE OF BIRTH MONTH DAY YEAR 12 17 1911		6. AGE (IN YEARS LAST BIRTHDAY) 67 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN		8. IF UNDER 24 HRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) BALTIMORE MD		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD					
10. CITY OR TOWN OF DEATH CITY		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SINAI HOSPITAL OF BALTO.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Sales Rep 10/79		12b. KIND OF BUSINESS OR INDUSTRY -			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD -				13b. COUNTY -		13c. CITY OR TOWN BALTIMORE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET 1014 N. EDEN ST	
14. FATHER'S NAME FIRST MIDDLE LAST MURPHY				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST FLYNN							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES -				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR RESERVE STATUS) 11-22-23-34-5054		17. INFORMANT ADDRESS Bernice Conway 3913 BALDWIN RD					
11. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMA OF PANCREAS 1579 DUE TO, OR AS A CONSEQUENCE OF (b) EXTENSIVE METASTASES DUE TO, OR AS A CONSEQUENCE OF (c) - 11-6-79										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION -		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED -				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. - 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) -							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) -		21f. LOCATION STREET -		CITY OR TOWN -		COUNTY -		STATE -	
22. I certify that (I) (this hospital) attended the deceased from 11-6-1979, to 12-22-1979, that (I) (we) lost saw the deceased alive on 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE ASWANI 9159				DEGREE MD.				ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 12-22-79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) HARESH ASWANI				22e. ADDRESS SINAI HOSPITAL OF BALTO.							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12/26/79		23c. NAME OF CEMETERY OR CREMATORY ARBURUS		23d. LOCATION (CITY OR TOWN) BALTO MD		COUNTY MD		STATE MD	
24. FUNERAL DIRECTOR Name Address 1717 N. W. 11th St 63879, 1, no 54						25a. DATE REC'D. BY REGISTRAR DEC 24 1979		25b. REGISTRAR'S SIGNATURE Fitzgerald			



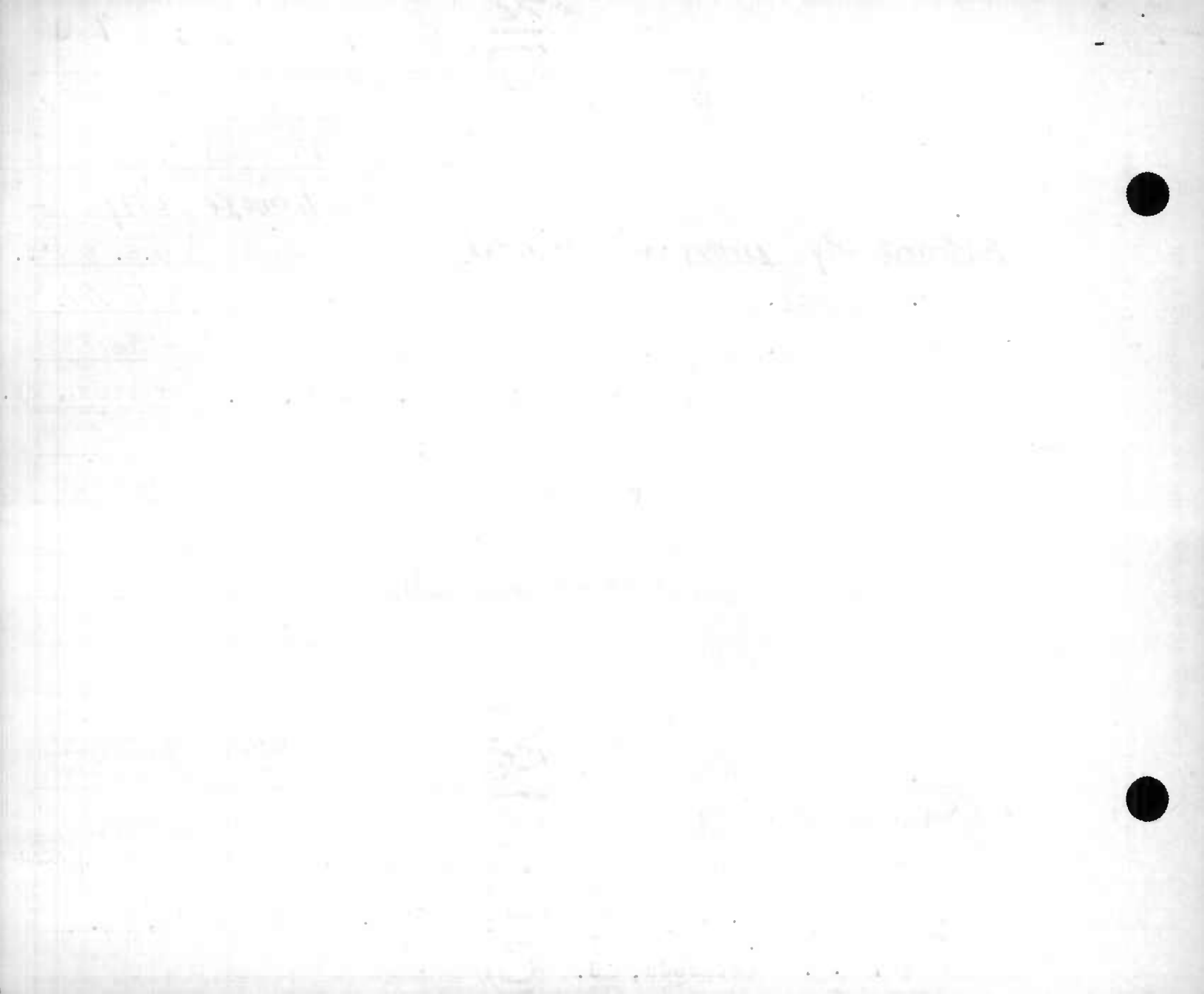
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR					REG. NO. 79 30270				
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ANN B KENNEY					2a. DATE OF DEATH MONTH DAY YEAR 12 29 79			2b. HOUR 0815 P.M.	
3. SEX FEMALE		4. RACE CAUCASIAN		5. DATE OF BIRTH MONTH DAY YEAR 11 21 00		6. AGE (IN YEARS LAST BIRTHDAY) 79 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pa.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore city MD.			
10. CITY OR TOWN OF DEATH Baltimore city		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Lutheran Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Accountant		12b. KIND OF BUSINESS OR INDUSTRY U.S. Gov't.	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE 13b. COUNTY 13c. CITY OR TOWN Md. Montg. Silver Spring					13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 8114 New Hampshire Ave.		
14. FATHER'S NAME FIRST MIDDLE LAST Judson W. Kenney					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Laura Buechley				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No					16b. SOCIAL SECURITY NO. 170-05-7055		17. INFORMANT ADDRESS Box 151 Benton C. Tolley, Jr. Georgetown, Del.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac pulmonary Arrest</u> 5990 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <u>Septic Shock</u> (c) <u>Chronic Urinary Tract Infection</u> DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 days years									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>pneumonia, bilaterally</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>12/29</u> 19 <u>79</u> , to <u>12/29</u> 19 <u>79</u> , that (I) (we) last saw the deceased alive on <u>12/29</u> 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE David K. Tolley M.D.					DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			22c. DATE SIGNED 12/29/79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DAVID K. TOLLEY, M.D.					22e. ADDRESS Lutheran Hospital, Baltimore, Maryland.				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE Jan. 4, 1980		23c. NAME OF CEMETERY OR CREMATORY Metropolitan Cren.		23d. LOCATION CITY OR TOWN COUNTY STATE Alexandria, Va.			
24. FUNERAL DIRECTOR NAME Robert A. Pumphrey Homes, P.A. Bethesda, Md.					25a. DATE REC'D. BY REGISTRAR JAN 1 1980		25b. REGISTRAR'S SIGNATURE [Signature]		

BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 50M 1/76  
(VR A 15 (4))

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

7 9 3 0 2 7 1

FOR  
1 - STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>Ruby V. KENTON</b>			20. DATE OF DEATH MONTH DAY YEAR <b>12/2/79</b> 21. HOUR <b>5:55</b> AM		
3. SEX <b>F</b>	4. RACE <b>B</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>12 2 1937</b>	6. AGE (IN YEARS LAST BIRTHDAY) <b>42</b> YRS	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Md.</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH <b>Balto. City</b> MD.		
10. CITY OR TOWN OF DEATH <b>Balto</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>North Charles Gen. Hosp.</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Dental Assistant</b>	12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					
13a. STATE <b>Md</b>	13b. COUNTY <b>Balto</b>	13c. CITY OR TOWN <b>TOWSON</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS <b>408 Railroad Ave</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Leroy KENTON</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Elizabeth MACK</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>217-36-3978</b>	17. INFORMANT ADDRESS <b>315 Worley Rd White Marsh Md</b>		
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebrovascular Accident</b> <b>436-</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (b) <b>SEVERE CEREBRAL EDEMA</b> DUE TO, OR AS A CONSEQUENCE OF (c)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>Marcos B. Galicia Jr., MD</b>		DEGREE <b>MD</b>		22c. DATE SIGNED <b>12/2/79</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>MARCOS B. GALICIA Jr., MD</b>		22e. ADDRESS <b>North Charles Hosp.</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>12/6/79</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Pleasant Rest Cem</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Towson Balto Md.</b>
24. FUNERAL DIRECTOR NAME <b>Chatman F.H.</b>		ADDRESS <b>1701 McCulloh St</b>		25a. DATE REC'D. BY REGISTRAR <b>4 1979</b> REGISTRAR'S SIGNATURE <b>F. H. Chatman</b>	

MEDICAL CERTIFICATION

11-10-1911  
Dear Sir,  
I have the honor to acknowledge the receipt of your letter of the 10th inst. in relation to the matter mentioned therein.  
I am sorry to hear that you are unable to visit Chicago at the present time.  
I am sure that you will find the time to visit us at some future date.  
Very respectfully,  
[Signature]



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

7 9 3 0 2 7 2  
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>Jackson P. KETCHAM</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>December 14 1979</b>			2b. HOUR <b>8:00 P</b>				
3 SEX <b>Male</b>		4 RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Nov. 18 1905</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>74</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>N.Y.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 <b>BALTIMORE CITY</b> OR COUNTY OF DEATH <b>Baltimore City</b> MD.				
10 CITY OR TOWN OF DEATH <b>Balto.</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Union Memorial Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Architect</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Self Employ.</b>		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Md.</b>					13b. COUNTY		13c. CITY OR TOWN <b>Balto.</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14 FATHER'S NAME FIRST MIDDLE LAST <b>Charles A Ketcham</b>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Blanche Young</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>			16b. SOCIAL SECURITY NO. <b>212-03-3388</b>		17 INFORMANT <b>Margaret P. Ketcham</b>			ADDRESS <b>Same</b>		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Sclerotic Heart Disease</b> <b>4140</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost } DUE TO, OR AS A CONSEQUENCE OF (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>26 years</b>		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
19a. DATE OF OPERATION —			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED —			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) —				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) —			21f. LOCATION STREET CITY OR TOWN COUNTY STATE —				
22a. I certify that (I) (this hospital) attended the deceased from <b>October 9 19 53</b> to <b>December 14 19 79</b> , that (I) (we) lost saw the deceased alive on <b>December 12 19 79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <b>W. Grafton Hersperger</b>					DEGREE		22c. DATE SIGNED <b>12/16/1979</b>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>W. Grafton Hersperger M.D.</b>					22e. ADDRESS <b>4206 Charlcote Rd., Balto., Md.</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>12-17-79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Druid Ridge</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Pikesville Balto Md.</b>			
24 FUNERAL DIRECTOR NAME <b>Henry W. Jenkins &amp; Sons Co., Balto., Md.</b>					ADDRESS <b>4905 York Rd.</b>		25a. DATE REC'D. BY REGISTRAR <b>DEC 17 1979</b>		25b. <b>1/1/1980</b>	

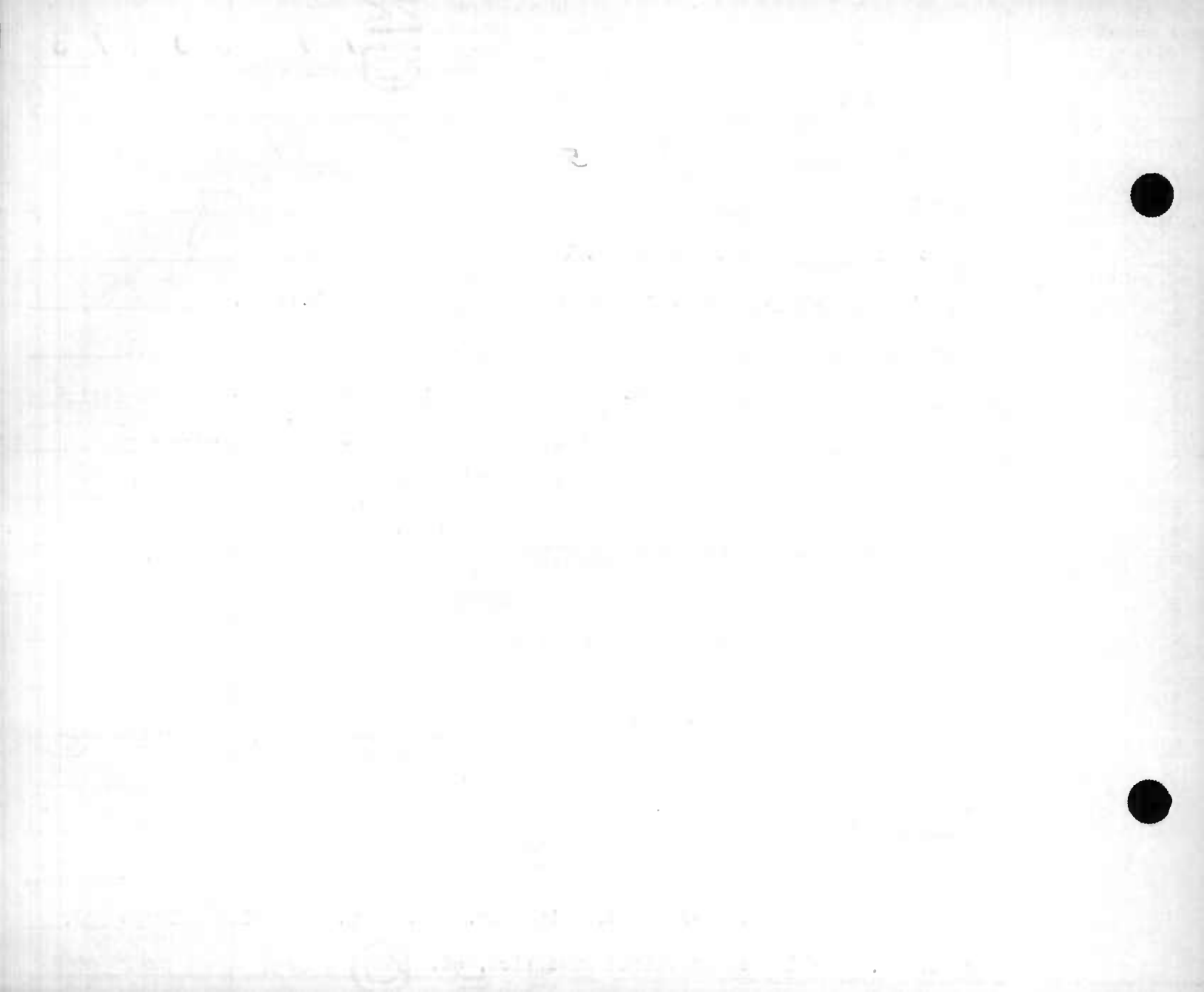


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		7 9 3 0 2 7 3 REG. NO.							
1. DECEASED NAME (TYPE OR PRINT) <b>ARTHUR KING</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>12-18-79</b>		2b. HOUR <b>5:05 PM</b>			
3. SEX <b>MALE</b>		4. RACE <b>Black</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>June 6 1955</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>84</b> YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
8. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		9. CITIZEN OF WHAT COUNTRY? <b>USA</b>		10. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		11. BALTIMORE CITY OR COUNTY OF DEATH <b>City</b> MD.			
12. CITY OR TOWN OF DEATH <b>Baltimore</b>		13. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Luthern Hospital</b>				14. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Labor</b>		15. KIND OF BUSINESS OR INDUSTRY	
16. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 16a. STATE <b>Maryland</b>		16b. COUNTY <b>Calvert</b>		16c. CITY OR TOWN <b>Pr. Frederick</b>		17. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		18. STREET ADDRESS <b>Kings Rd.</b>	
19. FATHER'S NAME FIRST MIDDLE LAST <b>Josepe King</b>				20. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Annie Hicks</b>					
21. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b>		22. (IF YES, GIVE WAR OR DATES) <b>WW1</b>		23. SOCIAL SECURITY NO. <b>218-14-3659</b>		24. INFORMANT ADDRESS <b>Estelle King Kings Rd. Prince Frederick</b>			
25. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>RESPIRATORY FAILURE RES 2° ASPHYXIA</b> 5990 DUE TO, OR AS A CONSEQUENCE OF (b) <b>SEPSIS 2° URINARY TRACT INFECTION</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>CHRONIC BRAIN SYND.</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)									
26. DATE OF OPERATION		27. CONDITION FOR WHICH OPERATION WAS PERFORMED				28. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		29. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
30. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		31. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		32. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
33. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		34. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		35. LOCATION STREET CITY OR TOWN COUNTY STATE					
36. I certify that (I) (this hospital) attended the deceased from <b>12-18-79</b> to <b>12-18-79</b> , that (I) (we) last saw the deceased alive on <b>12-18-79</b> and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
37. SIGNATURE <b>Abdul Samad Khan</b>				38. DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				39. DATE SIGNED <b>12-18-79</b>	
40. PHYSICIAN'S NAME (TYPE OR PRINT) <b>ABDUL SAMAD KHAN</b>				41. ADDRESS <b>VIHAREN HOSPITAL OF MARYLAND</b>					
42. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		43. DATE <b>Dec. 22-79</b>		44. NAME OF CEMETERY OR CREMATORY <b>Mt. Olive Chr. Cem.</b>		45. LOCATION CITY OR TOWN COUNTY STATE <b>Pr. Frederick Calvert Md.</b>			
46. FUNERAL DIRECTOR NAME <b>Spencer E. Sewell</b>				47. ADDRESS <b>Box 31 Prince Frederick, Md.</b>		48. DATE REC'D. BY REGISTRAR <b>DEC 24 1979</b>		49. REGISTRAR'S SIGNATURE <b>L. H. H. H.</b>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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(M)

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										7 9 3 0 2 7 4	
1- FOR STATE REGISTRAR					REG. NO.						
1. DECEASED NAME (TYPE OR PRINT) <b>HERMAN FORD KING JR.</b>					2a. DATE OF DEATH MONTH DAY YEAR <b>12 22 79</b>					2b. HOUR <b>M</b>	
3. SEX <b>Male</b>		4. RACE <b>Negro</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>61</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>61</b> YRS		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN		8. IF UNDER 24 HRS HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>NEW JERSEY</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore</b> MD.					
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>939 N. Rutland Ave.</b>					12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Maryland</b>					13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Baltimore</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>HERMAN KING, JR.</b>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>BERTHA</b>					16. STREET ADDRESS <b>939 Rutland Avenue</b>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Unkn.</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>Unkn.</b>		17. INFORMANT <b>Ruth King</b>		18. ADDRESS <b>Same As Above</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>ALCOHOLIC CARDIOMYOPATHY</b> <b>42535</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>ETOH ABUSE</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <b>10/78</b> , 19____, to <b>12/79</b> , 19____, that (I) (we) lost saw the deceased alive on <b>12/19</b> , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>R O Brennan</b>		DEGREE <b>MD</b>		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>12/22/79</b>					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>R O BRENNAN MD</b>		22e. ADDRESS <b>John Hopkins Hospital</b>									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>12-26-79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>KING MEM. PK.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>BALTIMORE CO., MD.</b>					
24. FUNERAL DIRECTOR NAME <b>Wm. C. March F/H</b>		ADDRESS <b>1101 E. North Ave.</b>		25. DATE REC'D. BY REGISTRAR <b>DEC 26 1979</b>		25b. REGISTRAR'S SIGNATURE <b>Henry McCreedy</b>					



MA 4711

NOTION 1000



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										7 9 3 0 2 7 5			
FOR 1. STATE REGISTRAR		REG. NO.											
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR
JOSEPH		A.		KING		Jr.		DECEMBER 10, 1979					2:07P M
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
Male		White		Oct. 21, 1918		61 YRS.		MONTHS		DAYS		HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH							
Maryland		United States				Baltimore City						MD	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY							
Baltimore		Church Hospital Corporation		Mechanic		Automobile							
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS					
Maryland		---		Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		803 N. Collington Ave.					
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME											
FIRST MIDDLE LAST		FIRST MIDDLE LAST											
Joseph Alva King		Unknown											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT		ADDRESS							
NO		211-16-0785A		Helen King		803 N. Collington Ave.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY SEVERE RESPIRATORY FAILURE										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
IMMEDIATE CAUSE (a) 4919													
DUE TO, OR AS A CONSEQUENCE OF (b) SEVERE CHRONIC BRONCHITIS WITH COR PULMONALE													
DUE TO, OR AS A CONSEQUENCE OF (c)													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?							
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that (I) (this hospital) attended the deceased from 12-10-79 to 12-10-79, that I (we) did saw the deceased alive on 12-10-79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) did not view the body after death.													
22b. SIGNATURE		DEGREE		ATTENDING <input checked="" type="checkbox"/> MEDICAL <input type="checkbox"/> STAFF <input type="checkbox"/> PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED							
C. S. CHEN						12-10-79							
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS											
C. S. CHEN		CHURCH HOSPITAL CORPORATION											
		100 N. BROADWAY, BALTIMORE, MD 21231											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE							
Burial		Dec. 13, 1979		Mt. Carmel Cemetery		Baltimore Maryland							
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE							
Lilly & Zeiler Inc.		1901 Eastern Ave./21231		DEC 12 1979		[Signature]							

21500 PT



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[Faint, mostly illegible text and markings covering the majority of the page, possibly representing a ledger or form with multiple rows and columns.]





1- FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

7 9 3 0 2 7 6

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST WILLIAM ELMER KING			2a. DATE OF DEATH MONTH DAY YEAR December 17, 1979			2b. HOUR P. M.			
3 SEX Male		4 RACE White		5 DATE OF BIRTH MONTH DAY YEAR Feb. 14, 1889		6 AGE (IN YEARS LAST BIRTHDAY) 90 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
8. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		9b. CITIZEN OF WHAT COUNTRY? U S A		10. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.			
10 CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 22 S. Athol Avenue				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Sales		12b. KIND OF BUSINESS OR INDUSTRY Retired	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland			13b. COUNTY		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST William Alfred King			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Emma Frances unknown			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no			
16b. SOCIAL SECURITY NO. 197-01-6063			17. INFORMANT 22 S. Athol Avenue General German Aged Peoples Home						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Liver decompensation</u> DUE TO, OR AS A CONSEQUENCE OF: (b) <u>metastatic Carcinoma</u> DUE TO, OR AS A CONSEQUENCE OF: (c) <u>Carcinoma of Colon</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)									
19a. DATE OF OPERATION 1978		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Carcinoma of Colon				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M.		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>June 1977</u> 19 <u>77</u> to <u>17 Dec</u> 19 <u>79</u> , that (I) (we) lost saw the deceased alive on <u>17 Dec</u> 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death <u>77</u>									
22b. SIGNATURE <u>William J. Bryson</u> DEGREE <u>M.D.</u>						22c. DATE SIGNED 18 Dec 79			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. William J. Bryson						22e. ADDRESS 5772 Westview Mall, Catonsville, Md.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12/19/79		23c. NAME OF CEMETERY OR CREMATORY Lorraine Park Cem		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Maryland			
24. FUNERAL DIRECTOR NAME Witzke Catonsville Funeral Home, P.A. 21228						25a. DATE REC'D. BY REGISTRAR DEC 20 1979		25b. REGISTRAR'S SIGNATURE <u>Robert McCreedy</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of same.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at 1-800-338-1111.

## MEDICAL CERTIFICATION

1- FOR STATE REGISTRAR					STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					7 9 30277 REG. NO.				
1. DECEASED NAME (TYPE OR PRINT) <b>James M. KIRBY</b>					2a. DATE OF DEATH MONTH DAY YEAR <b>December 10 1979</b>					2b. HOUR <b>12:20PM</b>				
3 SEX <b>Male</b>		4 RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>11/27/90</b>			6. AGE (IN YEARS (LAST BIRTHDAY)) <b>89</b> YRS.		# UNDER 1 YEAR MONTHS DAYS		# UNDER 24 HRS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Md.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.							
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Maryland General Hospital</b>					12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Ret. Administrator</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>Civil Service</b>				
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Md.</b>		13b. COUNTY <b>Balto.</b>		13c. CITY OR TOWN <b>Balto.</b>			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>3939 Roland Ave.</b>					
14. FATHER'S NAME FIRST MIDDLE LAST <b>Michael J. Kirby</b>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Mary Elliott</b>									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>212-07-7933</b>		17. INFORMANT ADDRESS <b>Ruth E. Pfeiffer, 936 Sedgley Rd.</b>										
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Congestive Heart Failure</b> <b>4292</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic Cardiovascular Disease</b> DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): <b>Diabetes Mellitus</b>														
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE								
22a. I certify that <b>KX</b> (this hospital) attended the deceased from <b>December 7</b> , 19 <b>79</b> , to <b>December 10</b> , 19 <b>79</b> , that <b>KX</b> (we) last saw the deceased alive on <b>December 10</b> , 19 <b>79</b> , and that in <b>KX</b> (our) opinion death occurred on the date and hour and from the causes stated above, <b>KX</b> (we) (did) (did not) view the body after death.														
22b. SIGNATURE <b>Michael E. Hull</b>					DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>					22c. DATE SIGNED <b>12-10-79</b>				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Michael E. Hull, M.D.</b>					22e. ADDRESS <b>c/o Maryland General Hospital</b>									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Entombment</b>			23b. DATE <b>12-13-79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Lorraine Park</b>			23d. LOCATION CITY OR TOWN COUNTY STATE <b>Balto. Md.</b>						
24. FUNERAL DIRECTOR NAME ADDRESS <b>Leonard J. Ruck, Inc., 5305 Harford Rd.</b>					25a. DATE REC'D. BY REGISTRAR <b>DEC 11 1979</b>					25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>				

1 30 11

December 10 1973 KIRBY James

Baltimore City

Baltimore General Hospital

1015 East Ave

Michael

1117 7 7032

Connective Heart Failure

Arteriosclerotic Cardiovascular Disease

Diabetes Mellitus

December 10 73 KX

December 10 73 KX

December 10 73 KX

December 10 73 KX

December 10 73 KX

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the funeral director and completely filled in by the funeral director. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				7 9 3 0 2 7 8 REG. NO.					
1. FOR STATE REGISTRAR				2a. DATE OF DEATH MONTH DAY YEAR				2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST MARIE K KIRBY				DECEMBER 1 1979				12:06A	
3 SEX Female		4 RACE White		5 DATE OF BIRTH MONTH DAY YEAR Aug 27 1927		6 AGE (IN YEARS LAST BIRTHDAY) 52 YRS.		# UNDER 1 YEAR MONTHS DAYS # UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia		7b. CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.			
10 CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (E NAME IN SUCH FACILITY, GIVE STREET ADDRESS) JOHNS HOPKINS HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Dist of Col				13b. CITY OR TOWN Washington		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13d. STREET ADDRESS 1422 Ridge Place, S. E	
14. FATHER'S NAME FIRST MIDDLE LAST Charles E Kenner				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Lillian Connell					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 579 32 9634		17 INFORMANT ADDRESS William C Kirby 2802 63rd Ave Cheverly Md					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c): PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>CARDIO RESPIRATORY ARREST</u> <u>0389</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>HYPOXIA, ACIDOSIS, HYPOPERFUSION,</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>PROBABLE SEPSIS / MULTI-ORGAN FAILURE</u>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>IMMEDIATE</u> <u>FEW DAYS</u> <u>FEW WEEKS</u>	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>DIABETES MELLITUS, PLEURAL EFFUSIONS + INFILTRATES RESPIRATORY FAILURE</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>NOV. 30</u> 19 <u>79</u> to <u>NOV. 30</u> 19 <u>79</u> , that (I) (we) last saw the deceased alive on <u>NOV 30</u> 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>Joseph Knight</u>				DEGREE <u>M.D.</u>				22c. DATE SIGNED <u>12/1/79</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>JOSEPH KNIGHT</u>				22e. ADDRESS <u>JOHNS HOPKINS HOSPITAL, BALT, Md.</u>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		23b. DATE <u>12-4-79</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>		23d. LOCATION CITY OR TOWN COUNTY STATE <u>Suitland Maryland</u>			
24 FUNERAL DIRECTOR <u>Robert E Wilhelm</u> <u>Suitland Maryland</u>				25a. DATE REC'D. BY REGISTRAR <u>DEC 6 1979</u> 25b. REGISTRAR'S SIGNATURE <u>Larkin McCready</u>					

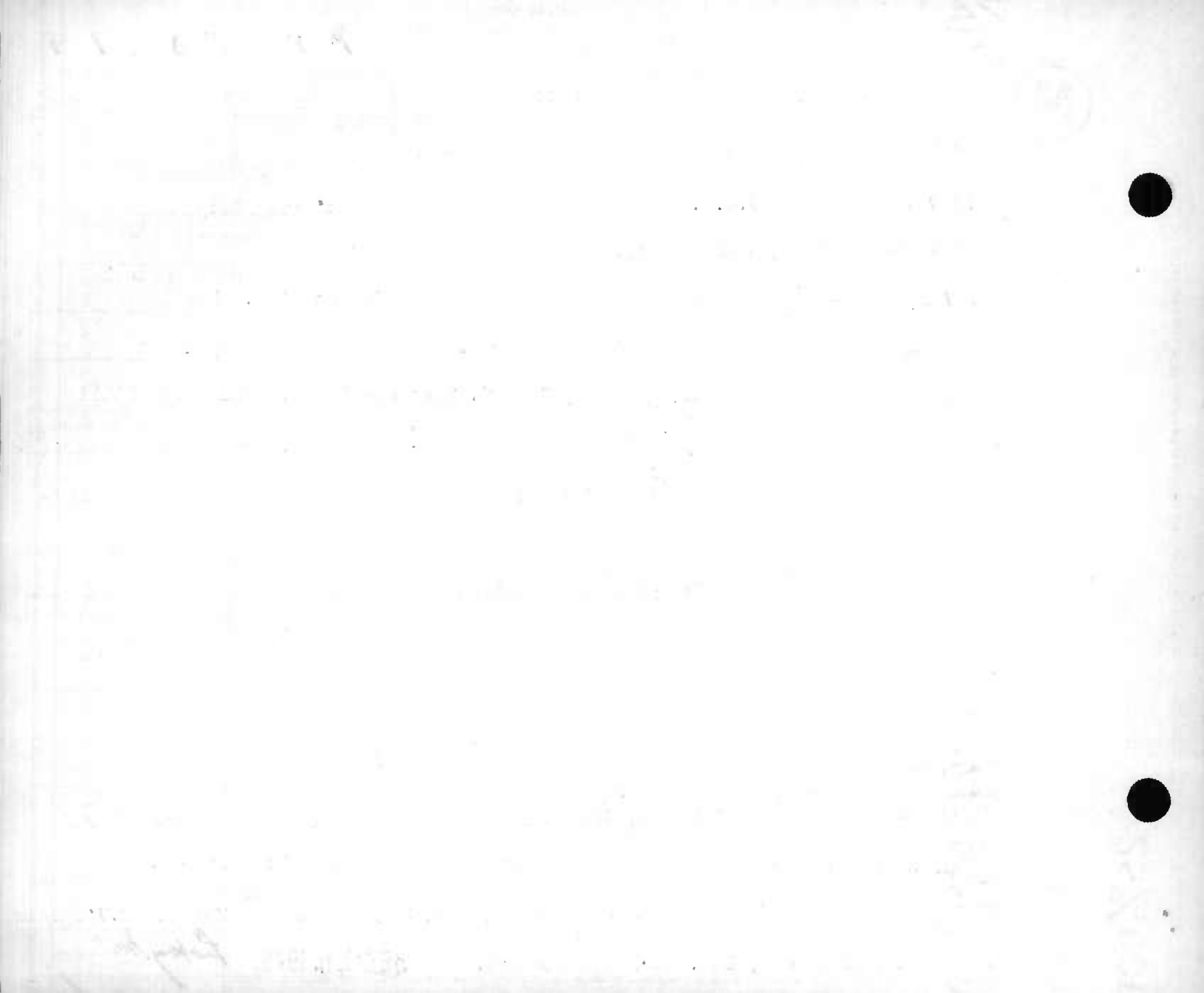


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 79 30279				
1. DECEASED NAME (TYPE OR PRINT)		FIRST Pearlie		MIDDLE		LAST Kittle		2a. DATE OF DEATH		MONTH 12	DAY 8	YEAR 79	2b. HOUR 645P <sup>M</sup>	
3 SEX Female		4 RACE White		5 DATE OF BIRTH MONTH 6 - DAY 16 - YEAR 1900		6 AGE (IN YEARS LAST BIRTHDAY) 79		7a. IF UNDER 1 YEAR MONTHS DAYS		7b. IF UNDER 24 HRS HOURS MIN.				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) West Virginia		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.								
10 CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Key Circle Hospice								12a. USUAL OCCUPATION (TYPE OF WORK FOR OCCUPATION OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE W. Virginia		13b. CITY Randolf		13c. CITY OR TOWN Elkins		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS Box-30 Route-2 Jackson Ave. 26241						
14 FATHER'S NAME FIRST Henry				MIDDLE		LAST Arbogast		15 MOTHER'S MAIDEN NAME FIRST Cordelia		MIDDLE		LAST Waybright		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) Unavailable		17 INFORMANT ADDRESS Glen W. Kisamore-209 S. Castle St. 21231								
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bilateral CVA</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Arteriosclerosis</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u></u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>Several months</u> <u>several years</u>		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <u>Chronic UTI</u>														
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)										
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE										
22a. I certify that (I) (this hospital) attended the deceased from <u>Nov. 30, 1978</u> , to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.														
22b. SIGNATURE <u>E. Ellsworth Cook</u>		DEGREE <u>MD.</u>		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>						22c. DATE SIGNED <u>12-8-79</u>				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) E. Ellsworth Cook				22e. ADDRESS 2431 Maryland Ave. Baltimore, Md.										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12-12-79		23c. NAME OF CEMETERY OR CREMATORY Parsons Family Cemetery		23d. LOCATION CITY OR TOWN Kerens		23e. COUNTY Tucker						
24 FUNERAL DIRECTOR NAME Hubbard Funeral Home, Inc.		ADDRESS 21229 4107 Wilkens Ave.		25a. DATE REC'D. BY REGISTRAR DEC 10 1979		25b. REGISTRAR'S SIGNATURE <u>Barney Helms</u>								





**STATE OF MARYLAND**  
**DEPARTMENT OF HEALTH AND MENTAL HYGIENE**  
**CERTIFICATE OF DEATH**

REG. NO.

7 9 3 0 2 8 0

FOR  
1. STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>Arthur F. Klair</b>		2a. DATE OF DEATH MONTH DAY YEAR <b>12-28-79</b>		2b. HOUR <b>1:20 A</b> M	
3 SEX <b>Male</b>	4 RACE <b>White</b>	5 DATE OF BIRTH MONTH DAY YEAR <b>July 28, 1913</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>66</b> YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Baltimore Md.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.		10 CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>St Agnes Hospital</b>	
12a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Maryland</b>		13b. COUNTY <b>Howard</b>		13c. CITY OR TOWN <b>5802 Meadowridge Road</b>	
14 FATHER'S NAME FIRST MIDDLE LAST <b>late Arthur F Klair</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Anna B Schlining</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>216 01 2159</b>		17. INFORMANT ADDRESS <b>Mary Klair 5802 Meadowridge Road 21227</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>ACVHD</b> <b>4029</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Hypertension</b> DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>15 yr</b> <b>15 yr</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>	
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	
21f. LOCATION STREET CITY OR TOWN COUNTY STATE		22a. I certify that (I) ( <del>the hospital</del> ) attended the deceased from <b>1-27-64</b> , 19____, to <b>12-28-79</b> , 19____, that (I) ( <del>was</del> ) last saw the deceased alive on <b>11-7</b> , 19 <b>79</b> , and that in (my) ( <del>our</del> ) opinion death occurred on the date and hour and from the causes stated above. (I) ( <del>was</del> ) ( <del>did not</del> ) view the body after death.			
22b. SIGNATURE <b>John F. Schaefer M.D.</b>		DEGREE		22c. DATE SIGNED <b>12/28/79</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>JOHN F. SCHAEFER M.D.</b>		22e. ADDRESS <b>5550 P.T. 40 WEST- 21228</b>		22f. MEDICAL ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>Dec 31, 1979</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Meadowridge</b>	
23d. LOCATION CITY OR TOWN COUNTY STATE <b>Howard, Maryland</b>		24. FUNERAL DIRECTOR NAME ADDRESS <b>Harry H. Witzke 4112 Columbia Road Ellicott City</b>		25a. DATE REC'D. BY REGISTRAR <b>DEC 31 1979</b>	
25b. REGISTRAR'S SIGNATURE <b>L. H. H. H. H.</b>					

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

BP





FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

100 39 63

7 100303020SLAV 8 1

REG. NO. 16

1 DECEASED NAME (TYPE OR PRINT) <b>CZESLAW KLAUZA</b>		2a DATE OF DEATH MONTH DAY YEAR <b>DEC. 6, 1979</b>		2b HOUR <b>8:25p<sub>M</sub></b>	
3 SEX <b>MALE</b>	4 RACE <b>WHITE</b>	5 DATE OF BIRTH MONTH DAY YEAR <b>7 17 1916</b>	6 AGE (IN YEARS LAST BIRTHDAY) <b>63</b> YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Poland</b>	7b CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9 BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE</b>		
10 CITY OR TOWN OF DEATH <b>BALTO</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>JOHN HOPKINS HOSPITAL</b>		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>STEVEDORE</b>		12b KIND OF BUSINESS OR INDUSTRY
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13a STATE <b>MD</b>	13b COUNTY <b>BALTO</b>	13c CITY OR TOWN <b>BALTO</b>	13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14 FATHER'S NAME FIRST MIDDLE LAST <b>STANISLAW KLAUZA</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>MARIA KLIMPA</b>			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b SOCIAL SECURITY NO. <b>2A-26-4496</b>		17 INFORMANT ADDRESS <b>MARIA KLAUZA 6709 BOSTON AVE</b>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>4412 Cardiac arrest after repair of ascending aortic aneurysm</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>13 min</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):					
19a DATE OF OPERATION <b>12/6/79</b>		19b CONDITION FOR WHICH OPERATION WAS PERFORMED <b>aortic aneurysm</b>		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE	
22a I certify that (1) (this hospital) attended the deceased from <b>12/4</b> , 19 <b>79</b> , to <b>12/6</b> , 19 <b>79</b> , that (1) (we) last saw the deceased alive on <b>12/6</b> , 19 <b>79</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did) (did not) view the body after death.					
22b SIGNATURE <b>Samuel Hassenbusch MD</b>		DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c DATE SIGNED <b>12/6/79</b>	
22d PHYSICIAN'S NAME (TYPE OR PRINT) <b>SAMUEL HASSENBUSCH</b>		22e ADDRESS <b>JOHNS HOPKINS HOSPITAL</b>			
23a BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b DATE <b>12-10-79</b>		23c NAME OF CEMETERY OR CREMATORY <b>ST. STARSHADS</b>	
23d LOCATION CITY OR TOWN COUNTY STATE <b>BALTO MD</b>		23e DATE REC'D. BY REGISTRAR <b>10 1979</b>		23f REGISTRAR'S SIGNATURE <b>Ricky McBrady</b>	
24 FUNERAL DIRECTOR NAME <b>JOHN M. WEBER &amp; SONS INC</b>		ADDRESS <b>100 S. CHESTER</b>			

MEDICAL CERTIFICATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

7 9 3 0 2 8 2

1. DECEASED NAME (TYPE OR PRINT) Isadore Klawans			2a. DATE OF DEATH MONTH DAY YEAR December 4, 1979			2b. HOUR 3:30 PM					
3. SEX male		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR AUG. 17, 1904		6. AGE (IN YEARS LAST BIRTHDAY) 75 YRS		7. UNDER 1 YEAR MONTHS DAYS		7b. UNDER 24 HRS HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) PENNSYLVANIA			7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore CITY MD.		
10. CITY OR TOWN OF DEATH BALTIMORE			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) The Johns Hopkins Hospital			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) SALESMAN			12b. KIND OF BUSINESS OR INDUSTRY SHOES		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE MARYLAND			13b. COUNTY		13c. CITY OR TOWN BALTIMORE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 4109 CRESTHEIGHTS RD. #21215		
14. FATHER'S NAME FIRST MIDDLE LAST ABRAHAM KLAUANSKY						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARY UNKNOWN					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 215-05-9266			17. INFORMANT MRS. IDA KLAUANS 4109 CRESTHEIGHTS RD. #21215					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) congestive heart failure 394/1 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) mitral valve disease (c) rheumatic fever (resuscitation) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 12/1, 1979, to 12/4, 1979, that (I) (we) last saw the deceased alive on 12/4, 3:30 PM, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Richard Ambwiler						DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 12/4/79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Richard Ambwiler						22e. ADDRESS THE JOHNS HOPKINS HOSP. - BALTO., MD					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE DEC. 6, 1979		23c. NAME OF CEMETERY OR CREMATORY SHAAREI ZION			23d. LOCATION CITY OR TOWN COUNTY STATE ROSEDALE BALTO. MD			
24. FUNERAL DIRECTOR NAME SOL LEVINSON & SONS, INC. 6010 REISTERSTOWN RD. BALTO., MD 21215						25a. DATE REC'D. BY REGISTRAR DEC 13 1979		25b. REGISTRAR'S SIGNATURE Richard Ambwiler			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified in writing.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR					7 9 3 0 2 8 3 REG. NO.				
2. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>MICHAEL Charles KLIPNER</b>					2a. DATE OF DEATH MONTH DAY YEAR <b>DECEMBER 31 1979</b>			2b. HOUR <b>10:00P</b>	
3 SEX <b>Male</b>		4 RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>8-31-57</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>22</b> YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN <b>0 0 0 0</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Md.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY</b> MD.			
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>JOHNS HOPKINS HOSPITAL</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Mechanical Engineer</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>CleveCon Corp.</b>	
13a. STATE <b>Md.</b>		13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>251 Cedarmere Cir., Owings Mills</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Russell Klipner</b>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Eileen Casey</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <b>Linda S. Klipner, 251 Cedarmere Cir.</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Respiratory Arrest</b> 0382 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>Intravascular Coagulation</b> (c) <b>Pneumococcal Sepsis</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>7d</b> <b>7d</b>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (1) (this hospital) attended the deceased from <b>12/31</b> , 19 <b>79</b> , to <b>12/31</b> , 19 <b>79</b> , that (1) (we) last saw the deceased alive on <b>12/31</b> , 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>Paul P. Scanlon</b>				DEGREE <b>M.D.</b>				22c. DATE SIGNED <b>12/31/79</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Paul D. Scanlon</b>				22e. ADDRESS <b>Johns Hopkins Hospital Balto, Md.</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>1-4-80</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Most Holy Redeemer</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore Md.</b>			
24. FUNERAL DIRECTOR NAME <b>Leonard J. Ruck, Inc., 5305 Harford Rd.</b>				25a. DATE REC'D. BY REGISTRAR <b>JAN 3 1980</b>		25b. REGISTRAR'S SIGNATURE <b>Patricia Melvody</b>			

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(VRA 15, 4) 1/79

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 only to be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at office.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				7 9 3 0 2 8 4 REG. NO.			
1. FOR STATE REGISTRAR							
1. DECEASED NAME (TYPE OR PRINT) Elizabeth Barbara Klotz				2a. DATE OF DEATH MONTH DAY YEAR December 15, 1979			
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Jan 6, 1898		6. AGE (IN YEARS LAST BIRTHDAY) 81 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.	
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) South Baltimore Gen. Hosp.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)							
13a. STATE Md.		13b. COUNTY A.A.		13c. CITY OR TOWN Linthicum		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Andrew Fabula				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Barbara			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES) 212-03-1935		17. INFORMANT ADDRESS William O. Klotz Jr. same as 13 e			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac arrest</u> 4292 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Arteriosclerotic cardiovascular disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>and Diabetes Mellitus</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 19 to 12-15-1979, that (I) (we) last saw the deceased alive on 12-15-1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>See Nivasa</u>				DEGREE		22c. DATE SIGNED 12/17/79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) SEE NIVASA				22e. ADDRESS 615 Hammond Lane, BALTO, 21225			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12/19/79		23c. NAME OF CEMETERY OR CREMATORY Holy Redeemer Cem		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Maryland	
24. FUNERAL DIRECTOR NAME George J. Gonce 4001 Ritchie Hwy				25a. DATE REC'D. BY REGISTRAR DEC 18 1979		25b. REGISTRAR'S SIGNATURE <u>R. J. McCreary</u>	

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December 15, 1993

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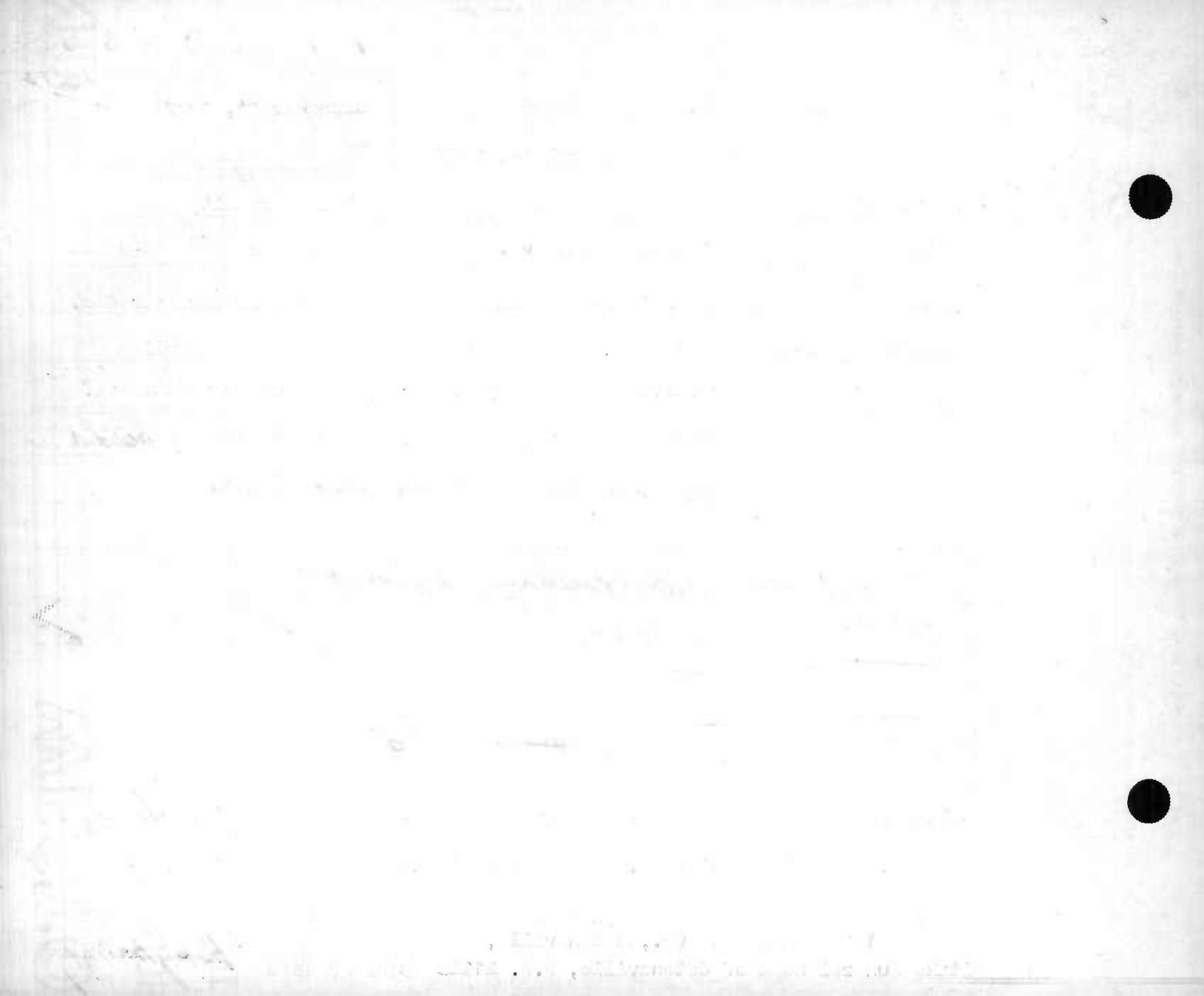
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed in the office 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
1. FOR STATE REGISTRAR		7 9 3 0 2 8 5		REG. NO.							
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR MIN	
HELEN		M.		KNARR				December 11, 1979		6 10 AM	
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN	
Female		White		March 28, 1907		72					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
Pennsylvania		U S A				Baltimore City MD.					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)									
Baltimore		4002 Massachusetts Ave.									
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY									
Bookkeeper		Retired									
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS			
Maryland				Baltimore				4002 Massachusetts Ave.			
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST									
William Joseph Campbell		Grace McMullen									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES)		17. INFORMANT ADDRESS		21229					
no		217-07-3092A		Mary C. Knarr, 4002 Massachusetts Ave.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (a) <i>acute myocardial infarction, probable</i>										<i>sudden</i>	
410- DUE TO, OR AS A CONSEQUENCE OF (b) <i>Coronary atherosclerotic heart disease</i>											
DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i>previous cerebrovascular Accident</i>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
none		none									
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
		P.M. 19									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE	
22a. I certify that (I) (this hospital) attended the deceased from <i>9/11</i> 19 <i>79</i> , to <i>12/11</i> 19 <i>79</i> , that (I) (we) last saw the deceased alive on <i>9/11</i> 19 <i>79</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED					
<i>Dionisio Garcia Jr.</i>		Dr. Dionisio Garcia, Jr.				12/11/79					
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS									
Dr. Dionisio Garcia, Jr.		5550 Baltimore National Pike, 21228									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN		COUNTY		STATE	
Burial		12/13/79		Baltimore National		Baltimore		Maryland			
24. FUNERAL DIRECTOR NAME		1630 Edmondson Ave., Catonsville, Md		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
Witzke Funeral Home of Catonsville, P.A. 21228				DEC 13 1979		<i>Robert McCreedy</i>					

BP



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

7 9 3 0 2 8 6

1- FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>RALEIGH L. KNIGHT JR.</b>		2a. DATE OF DEATH MONTH DAY YEAR <b>12 6 79</b>		2b. HOUR <b>145 PM</b>
3 SEX <b>MALE</b>	4 RACE <b>Black</b>	5 DATE OF BIRTH MONTH DAY YEAR <b>5 31 19 60</b>	6 AGE (IN YEARS LAST BIRTHDAY) <b>60</b> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>VA. (USA)</b>	7b. CITIZEN OF WHAT COUNTRY? <b>American</b>	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore</b> MD.	
10. CITY OR TOWN OF DEATH <b>Baltimore</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Sina Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>MARYLAND</b>		13b. COUNTY	13c. CITY OR TOWN <b>Baltimore</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
13e. STREET ADDRESS <b>2nd Floor 1226 North Broadway St.</b>				
14 FATHER'S NAME FIRST MIDDLE LAST <b>LEN Knight</b>	15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Evelyn Knight</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>	16b. SOCIAL SECURITY NO. <b>218-14-9038</b>	17 INFORMANT ADDRESS <b>Betty Tate 2221 East Preston St.</b>		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>cardio pulmonary arrest</b> <b>185-</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>pulmonary edema</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (c) <b>Ca of prostate 2 metacran</b>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)				
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19 12 13 179</b>		
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		21d. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		
21e. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <b>12/13/79</b> to <b>12/16/79</b> , that (I) (we) lost saw the deceased alive on <b>12/16/79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.				
22b. SIGNATURE <b>THANK 7 EN</b> DEGREE <b>MD</b>		22c. DATE SIGNED		22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Sina Hosp</b>
22e. ADDRESS				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>	23b. DATE <b>12/8/1979</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Church Cemetery</b>	23d. LOCATION CITY OR TOWN COUNTY STATE <b>Ontario City, Virginia</b>	
24. FUNERAL DIRECTOR NAME ADDRESS <b>Wm. C. March F/H 1101 East North Avenue</b>		25a. DATE REC'D. BY REGISTRAR <b>DEC 7 1979</b>		25b. REGISTRAR'S SIGNATURE <b>Harry A. Brady</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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BRIDGE N. KNIGHTS

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		7 9 3 0 2 8 7 REG. NO.							
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST NORA ANN KOCH					2a. DATE OF DEATH MONTH DAY YEAR DECEMBER 24, 1979			2b. HOUR 8:25pm.	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR October 2, 1906		6. AGE (IN YEARS LAST BIRTHDAY) 73 YRS.		7. UNDER 1 YEAR MONTHS DAYS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.			
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) ST AGNES				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Packager		12b. KIND OF BUSINESS OR INDUSTRY Calvert Dist.	
13a. STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN Arbutus		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 5827 Oakland Road, 21227	
14. FATHER'S NAME FIRST MIDDLE LAST John George Vogel					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Rose May McKewen				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 214-01-6205		17. INFORMANT ADDRESS Wilbur F. Cook, 35 Waveney Rd., Framingham, MA. 01701					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>septic shock</u> 5698 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>fecal peritonitis</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>perforated colon</u>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).									
19a. DATE OF OPERATION 12/23/79		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED perforated colon				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>12/22</u> 19 <u>79</u> , to <u>12/24</u> 19 <u>79</u> , that (I) (we) last saw the deceased alive on <u>12/24</u> 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>Dr. Victor Haddad</u>					DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 12/24/79		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Victor Haddad					22e. ADDRESS 900 S. CATON AVE., BALTO., MD. 21229				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12-28-79		23c. NAME OF CEMETERY OR CREMATORY Holy Cross Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Brooklyn Pk. Anne Arundel, Md.			
24. FUNERAL DIRECTOR NAME Hubbard Funeral Home Inc 4107 Wilkens Ave 21229					25a. DATE REC'D. BY REGISTRAR DEC 28 1979		25b. SIGNATURE <u>[Signature]</u>		







FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>Matthew</b> <b>Koebrugge</b>			2a. DATE OF DEATH MONTH <b>12</b> DAY <b>9</b> YEAR <b>79</b>		2b. HOUR <b>8.25 AM</b>
3. SEX <b>Male</b>	4. RACE <b>W</b>	5. DATE OF BIRTH MONTH <b>12</b> DAY <b>9</b> YEAR <b>79</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>3 1/2 HRS</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MARYLAND</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. BALTIMORE CITY OR COUNTY OF DEATH <b>Balto city</b> MD.			10. CITY OR TOWN OF DEATH <b>Baltimore</b>		
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>MERCY HOSPITAL</b>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE <b>Maryland</b> 13c. COUNTY <b>ANNE ARUNDEL</b> 13d. CITY OR TOWN			13e. STREET ADDRESS <b>4540 Mountain Rd.</b>		
14. FATHER'S NAME FIRST <b>Richard</b> MIDDLE <b>Alon</b> LAST <b>Koebrugge</b>			15. MOTHER'S MAIDEN NAME FIRST <b>Antoinette</b> MIDDLE <b>Pilipauskis</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIAC ARREST</b> <b>7689</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>HYPOXIA</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) <b>EXTREME PREMATURITY</b>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>3 1/2 HRS</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>12/9</b> , 19 <b>79</b> , to <b>12/9</b> , 19 <b>79</b> , that (I) (we) lost saw the deceased alive on <b>12/9</b> , 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.					
22b. SIGNATURE <b>S. Ionides</b>		DEGREE <b>M.D.</b>		22c. DATE SIGNED <b>12/9/79</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>S. Ionides</b>		22e. ADDRESS <b>MERCY HOSPITAL</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Removal</b>		23b. DATE <b>12/13/79</b>		23c. NAME OF CEMETERY OR CREMATORY	
23d. LOCATION CITY OR TOWN COUNTY STATE		24. FUNERAL DIRECTOR NAME <b>Anatomy Board</b> ADDRESS <b>Balto., Md.</b>			
25a. DATE REC'D. BY REGISTRAR <b>DEC 17 1979</b>		25b. REGISTRAR'S SIGNATURE <b>Robert McCreedy</b>			

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

BP





POLY COTTON LEEB



STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
1. FOR STATE REGISTRAR		7 9 3 0 2 8 9 REG. NO.									
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR	
Josephine		Koros						12 14 79		3:40 PM	
3 SEX		4 RACE		5 DATE OF BIRTH MONTH DAY YEAR		6 AGE (IN YEARS LAST BIRTHDAY) YRS		7 IF UNDER 1 YEAR MONTHS DAYS		8 IF UNDER 24 HRS HOURS MIN	
Female		White		10 13 94		85					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH					
Poland		Poland - U.S.A.				Balto. City, MD.					
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Balto.		Caton Manor Nursing Center						HOUSEWIFE			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS			
Md.		Anne Arundel		Pasadena				514 Sylview Drive			
14. FATHER'S NAME FIRST MIDDLE LAST				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST							
Karol CzaJa				Marianne Stefan							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)				16b. SOCIAL SECURITY NO				17 INFORMANT ADDRESS			
No				212 42 9305				DREWE CZERWINSKI 514 SYLVIEW DR. 21122			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) RECURRENT CVA										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 24 hrs.	
4292 DUE TO, OR AS A CONSEQUENCE OF (b) ASCVD, advanced, generalized											
DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from 10/10/1977, to 12/14/1979, that (I) (we) lost the deceased alive on 12/14/1979, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (If I (we) did not view the body after death, so state.)											
22b. SIGNATURE		DEGREE						22c. DATE SIGNED			
Herbert J. Levickas, M.D.		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>						12/14/79			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS									
Herbert J. Levickas, M.D.		5404 East Drive Balto., Md. 21227									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE					
BURIAL		12-17-79		ST. STANIS LAUS		BALTO. MD					
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
THOMAS J. SKARDA		2829 HUDSON ST.		DEC 19 1979		[Signature]					



DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

30290

1. FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MARY P. LAST KRATSAS			2a. DATE OF DEATH MONTH 12 DAY 24 YEAR 79			2b. HOUR 7:00 AM	
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH MONTH 12 DAY 27 YEAR 11		6. AGE (IN YEARS LAST BIRTHDAY) XXXXX 68 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) VA		7b. CITIZEN OF WHAT COUNTRY? U.S. A		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.	
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) S B G H		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Nurse		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD 13b. COUNTY Anne Arundel 13c. CITY OR TOWN Baltimore				13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 619 Regatta Ave.	
14. FATHER'S NAME FIRST wife name MIDDLE LAST Johnson				15. MOTHER'S MAIDEN NAME FIRST XXXXXXXX MIDDLE gertrude LAST Bruce			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 225-12-0368		17. INFORMANT Baltimore, Md. 21225 Mr. George N. Kratsas 619 Regatta Avenue			

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) cardiac - resp. arrest - DUE TO, OR AS A CONSEQUENCE OF (b) metabolic, renal DUE TO, OR AS A CONSEQUENCE OF (c) extension of the tumor		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
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PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 12/23/79, 19 29, to 12/24/79, 19 29, that (I) (we) last saw the deceased alive on 12/24/79, 19 5:00 AM and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE 20wipalil MD				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 12/24/79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) I. DEVI DATE 2				22e. ADDRESS S B G H			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12/29/79		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Anne Arundel Md.	
24. FUNERAL DIRECTOR NAME 237 G. Patapaca Avenue Balto., Md. 21225 Mc Cully Funeral Home of Brooklyn				25a. DATE REC'D. BY REGISTRAR DEC 28 1979		25b. REGISTRAR'S SIGNATURE [Signature]	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of occurrence.

FOR  
1 - STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

7 9 3 0 2 9 1

1. DECEASED NAME (TYPE OR PRINT) <b>LOUIS B. KRAVETZ</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>12- 12-22-79</b>			2b. HOUR <b>1 53<sup>PM</sup></b>		
3. SEX <b>MALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>5 20 03</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>76</b> YRS.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>RUSSIA POLAND</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTO CITY</b> MD.		
10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>SINAI HOSP</b>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>ENGINEER - LAW</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>GOV'T. LAW</b>	
13a. STATE <b>MARYLAND</b>				13b. COUNTY		13c. CITY OR TOWN <b>BALTIMORE</b>		
13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>				13e. STREET ADDRESS <b>2710-E JEREMY CT. #21209</b>				
14. FATHER'S NAME FIRST MIDDLE LAST <b>ISAAC KRAVETZ</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>CECELIA WOHL</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>213-14-5894</b>		17. INFORMANT <b>MRS. YETTA KRAVETZ</b> <b>2710 E. JEREMY CT. #21209</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>CARDIAC ARREST</b> <b>410 -</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (b) <b>MASSIVE MYOCARDIAL INFARCT</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>CORONARY VASCULAR DISEASE</b>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>INSTANT</b> <b>1 DAY</b> <b>4 YEARS</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)								
19a. DATE OF OPERATION <b>12-22-79</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>REFRACTORY BRADYCARDIA</b>			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <b>12-22-79</b> 19 <b>79</b> , to <b>12-22-79</b> 19 <b>79</b> , that (I) (we) last saw the deceased alive on <b>12-22-79</b> 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) did (did not) view the body after death.								
22b. SIGNATURE <b>S. Sabatier MD</b>				DEGREE <b>MD</b>		22c. DATE SIGNED <b>12-21-79</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>HENRY S SABATIER MD</b>				22e. ADDRESS <b>SINAI HOSPITAL</b>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>DEC. 27, 1979</b>		23c. NAME OF CEMETERY OR CREMATORY <b>BETH TFILOH</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>BALTIMORE MARYLAND</b>		
24. FUNERAL DIRECTOR NAME ADDRESS <b>SOL LEVINSON &amp; BROS., INC.</b> <b>6010 REISTERSTOWN RD. BALTO., MD 21215</b>				25a. DATE REC'D. BY REGISTRAR <b>JAN 3 1980</b>		25b. REGISTRAR'S SIGNATURE <i>R. J. M. M. M.</i>		





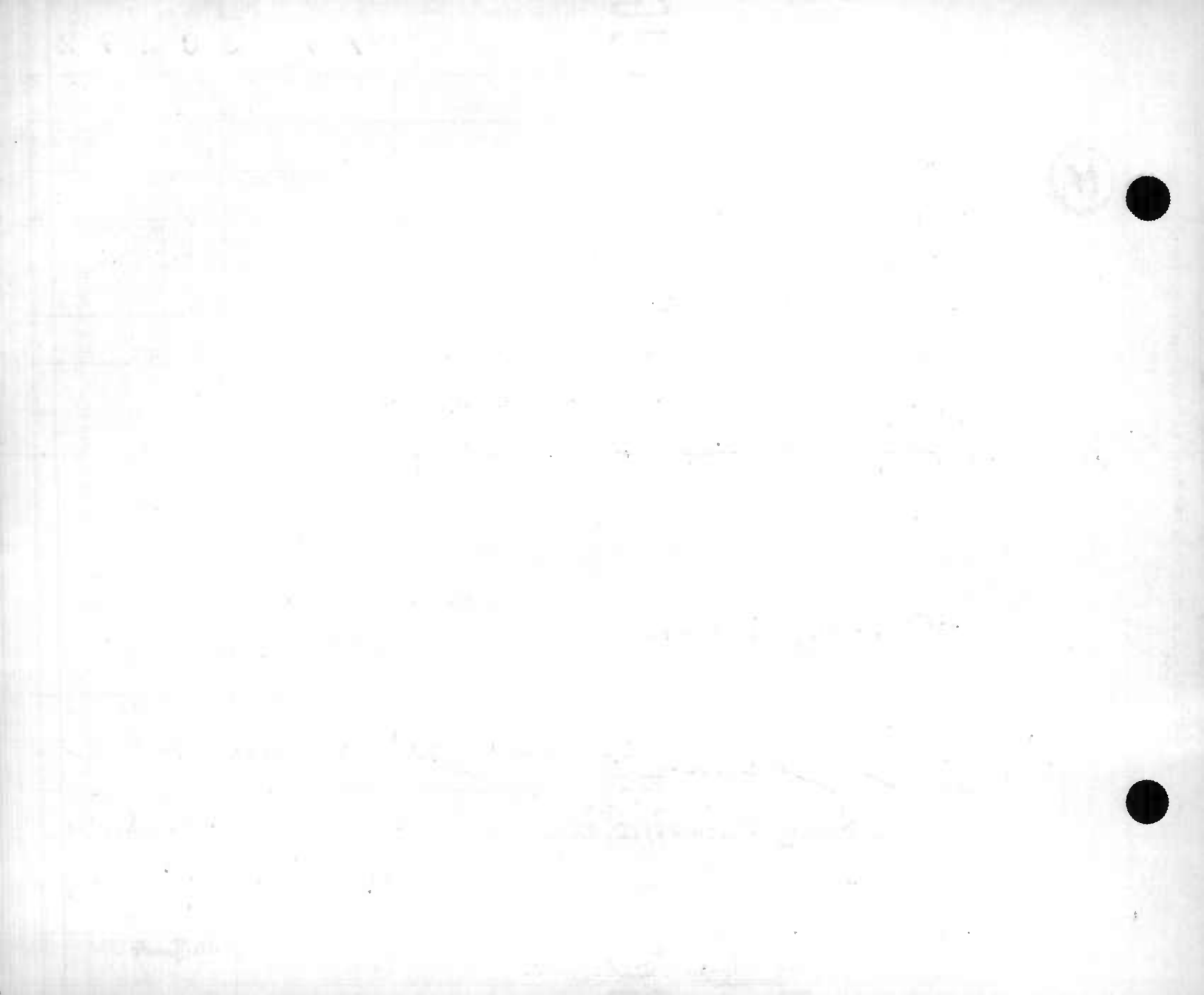


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at 1-800-35-0000.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				7 9 3 0 2 9 2 REG. NO.			
1. FOR STATE REGISTRAR DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>HALL B. KREBS</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>XX 12-23-1979</b>		2b. HOUR <b>M</b>	
3 SEX <b>MALE</b>		4 RACE <b>CAUCASION</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>2 20 1900</b>		6 AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS HOURS MIN. <b>79 YRS</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>PENN.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY MD.</b>	
10 CITY OR TOWN OF DEATH <b>BALTIMORE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>1105 ANDOVER ROAD</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>CLERK</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>RAILROAD</b>	
13a. STATE <b>MD.</b>		13b. COUNTY <b>--</b>		13c. CITY OR TOWN <b>Baltimore</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14 FATHER'S NAME FIRST MIDDLE LAST <b>Lewis Krebs</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Bertha Bullhart</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO <b>716-03-1173</b>		17 INFORMANT ADDRESS <b>Mary S. Krebs Same as # 13</b>			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma prostate</b> <b>185-</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost: _____							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____							
19a. DATE OF OPERATION <b>28 February 1977</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Ca prostate</b>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>2 February 1977</b> to <b>23 December 1979</b> , that (I) <input checked="" type="checkbox"/> saw the deceased alive on <b>10 December 1979</b> , and that in (my <input checked="" type="checkbox"/> / our) opinion death occurred on the date and hour and from the causes stated above, (I) <input checked="" type="checkbox"/> (we) <input type="checkbox"/> (did) <input type="checkbox"/> (did not) view the body after death.							
22b. SIGNATURE <b>John N Barnaby MD</b>		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>26 Dec 79</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>John Barnaby, M.D.</b>				22e. ADDRESS <b>1652 East Belvedere, Baltimore, Md. 21239</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Removal</b>		23b. DATE <b>12-23-1979</b>		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE	
24 FUNERAL DIRECTOR NAME ADDRESS <b>ANATOMY BOARD OF MD. Baltimore, Md.</b>				25a. DATE REC'D. BY REGISTRAR <b>DEC 28 1979</b>		25b. REGISTRAR'S SIGNATURE <b>Henry M. Barnaby</b>	



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1b. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 30293	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Thomas L. Kreutzberg							2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR 12 22 19 79		2b. HOUR M 10:25 a		
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 2/21/1925		6. AGE (IN YEARS) LAST BIRTHDAY 54 YRS.		7. IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		7c. DATE PRONOUNCED DEAD MONTH DAY YEAR 12 22 19 79	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City, MD.		
10. CITY OR TOWN OF DEATH Baltimore City			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) University Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Glagier			12b. KIND OF BUSINESS Education	
13a. STATE Md.			13b. COUNTY Baltimore			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS 1102 Carroll St.		
14. FATHER'S NAME FIRST MIDDLE LAST Thomas J. Kreutzberg						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mrs. John Hardy					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) yes			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 214-22-2851			17. INFORMANT ADDRESS 1404 E. Curley St.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease 4292 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held on death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion											
ACTUAL SIGNATURE Thomas D. Smith				TITLE (SPECIFY) M.D. Deputy Chief				DATE SIGNED 12/22/79			
EXAMINER'S NAME (TYPE OR PRINT) Thomas D. Smith, M.D.				ADDRESS 111 Penn St. Balto., MD.							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 12/26/79		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cem.			23d. LOCATION CITY OR TOWN COUNTY STATE Anne Arundel Co. Md.			
24. FUNERAL DIRECTOR NAME John J. Cowan						ADDRESS 901 Hopkins St.		25a. DATE REC'D. BY REGISTRAR DEC 27 1979		25b. REGISTRAR'S SIGNATURE Harry Maloney	

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STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

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1 - FOR  
STATE  
REGISTRAR

REG. NO.

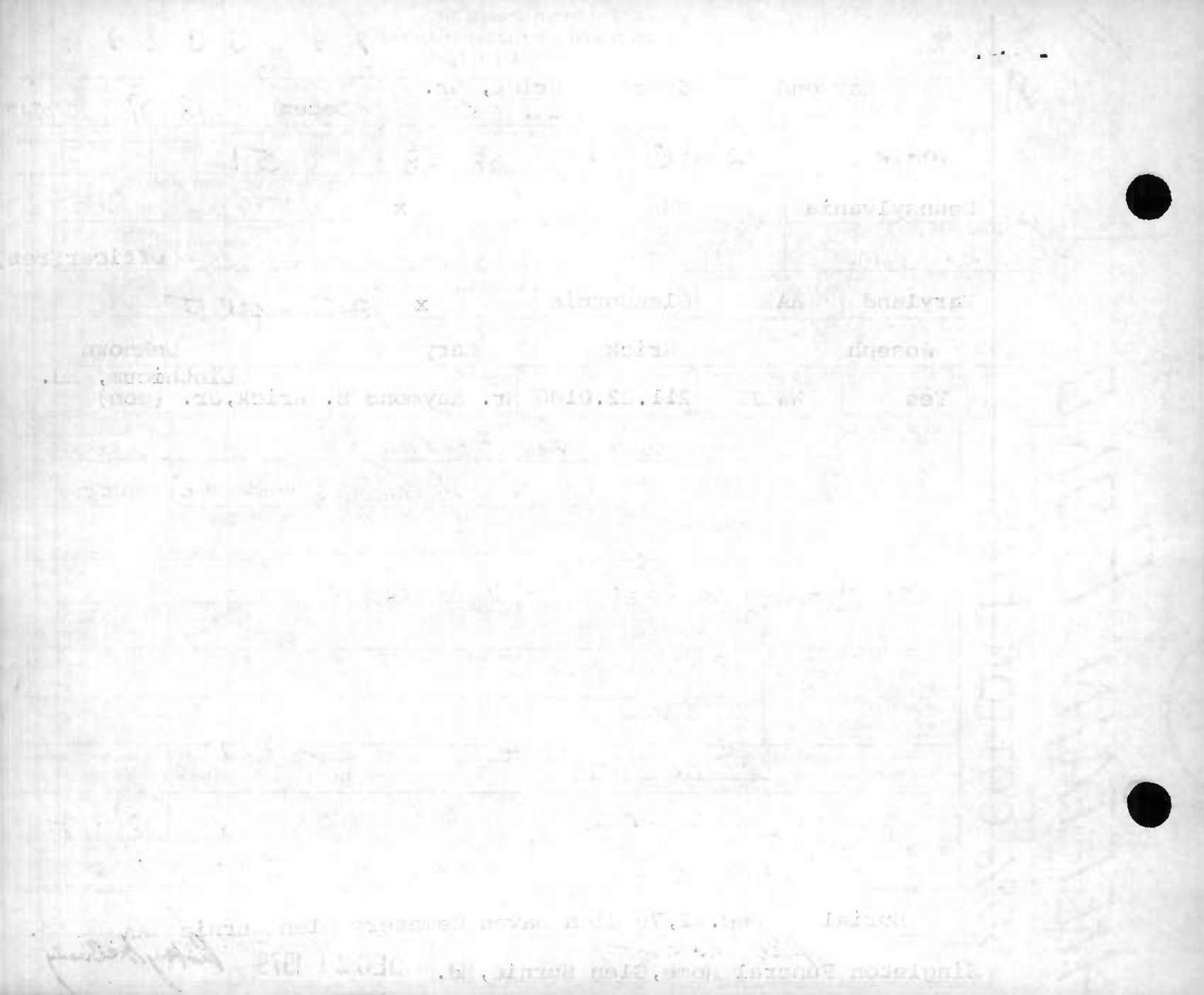
1. DECEASED NAME (TYPE OR PRINT) <b>Raymond Edward Krick, Sr.</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>December 18 79</b>		2b. HOUR <b>10:07 PM</b>						
3 SEX <b>male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>May - 28 - 28</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>51</b> YRS		# UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Pennsylvania</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.					
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Mercy Hospital, Inc.</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Baltimore City Police</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Officer (ret)</b>			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Maryland</b> 13b. COUNTY <b>AA</b> 13c. CITY OR TOWN <b>Glen Burnie</b>						13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>12 Juniper Ct.</b>			
14. FATHER'S NAME FIRST <b>Joseph</b> MIDDLE <b>Krick</b> LAST <b>Krick</b>				15. MOTHER'S MAIDEN NAME FIRST <b>Mary</b> MIDDLE <b>Unknown</b> LAST <b>Unknown</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b>		16b. SOCIAL SECURITY NO. <b>211.22.0180</b>		17. INFORMANT <b>Mr. Raymond E. Krick, Jr. (son)</b>		ADDRESS <b>Linthicum, Md.</b>					
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>massive oral Bleeding</b> <b>1490</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Carcinoma of Pharynx (unresectable)</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) <b>MONTHS</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>6 hours</b>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>Partial Airway obstruction 2° to tumor size</b>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19 79</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <b>12/4</b> , 19 <b>79</b> , to <b>12/18/79</b> , 19 <b>79</b> , that (I) (we) last saw the deceased alive on <b>12/18</b> , 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>John Smoke MD</b>				DEGREE				22c. DATE SIGNED <b>12/18/79</b>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>John Smoke MD</b>				22e. ADDRESS <b>Mercy Hosp Balt Md</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>Dec. 22, 79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Glen Haven Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Glen Burnie AA Md.</b>					
24. FUNERAL DIRECTOR NAME <b>Singleton Funeral Home, Glen Burnie, Md.</b> ADDRESS				25a. DATE REC'D. BY REGISTRAR <b>DEC 21 1979</b>		25b. REGISTRAR'S SIGNATURE <b>History McCreedy</b>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, this should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO. 79 30295

1. FOR STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT) <b>MARY K. Kwiepel (PFISTER)</b>		2a. DATE OF DEATH MONTH <b>12</b> DAY <b>20</b> YEAR <b>79</b>		2b. HOUR <b>6:45</b> M	
3. SEX <b>F</b>		4. RACE <b>W</b>		5. DATE OF BIRTH MONTH <b>1</b> DAY <b>4</b> YEAR <b>1884</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>85</b> YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore</b> MD.	
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Federal Hill Nursing Home</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>HOME</b>	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) <b>M.D.</b>		13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Baltimore</b>		13d. INSIDE CITY LIMITS YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST <b>MATHIAS</b> MIDDLE <b>BACKERT</b> LAST <b>BACKERT</b>		15. MOTHER'S MAIDEN NAME FIRST <b>MAGDALENE</b> MIDDLE <b>BACKERT</b> LAST <b>BACKERT</b>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>213-07-7673B</b>	
17. INFORMANT <b>Mr. Lawrence Brown</b>		17. ADDRESS <b>5527 Harbor Dr.</b>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <b>Arteriosclerotic Cardiovascular Disease</b> <b>4292</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): <b>Diabetes Mellitus</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>years</b>	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1; OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that I (this hospital) attended the deceased from <b>June 3</b> , 19 <b>77</b> , to <b>Dec. 20</b> , 19 <b>77</b> , that I (we) last saw the deceased alive on <b>Dec. 10</b> , 19 <b>77</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If not, I did not view the body after death.)		22b. SIGNATURE <b>Jon Mc Zimmerman MD.</b>		22c. DATE SIGNED <b>12/21/77</b>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>L. Zimmerman</b>		22e. ADDRESS <b>3202 Harbor Rd, Baltimore</b>		22f. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>12-24-1979</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Holy Redeemer</b>		23d. LOCATION CITY OR TOWN <b>Balto.</b> COUNTY <b>MD.</b> STATE <b>MD.</b>	
24. FUNERAL DIRECTOR NAME <b>Joseph M. Kelly</b> ADDRESS <b>7527 Harbor Rd</b>		25a. DATE REC'D. BY REGISTRAR <b>DEC 26 1979</b>		25b. REGISTRAR'S SIGNATURE <b>P. J. Kelly</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of it.

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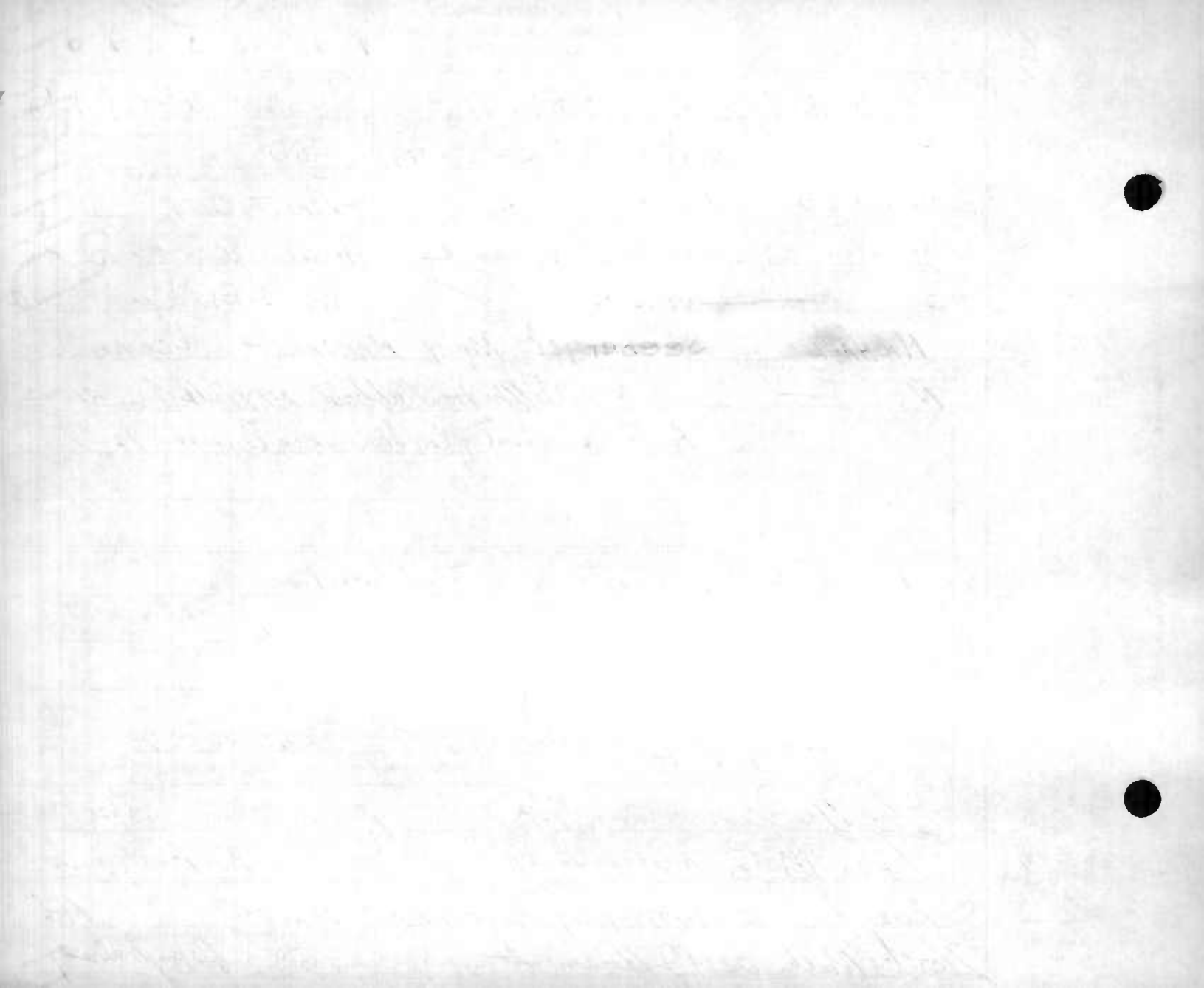
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR  
1. STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH1979 30296  
REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR
MARIE M. KRITZ					December	20	15	1979	12 <sup>15</sup> AM
3. SEX	F	4. RACE	white		5. DATE OF BIRTH	MONTH		DAY	YEAR
					8	2	99		
7a. BIRTHPLACE (COUNTRY)	Baltimore MD		7b. CITIZEN OF WHAT COUNTRY?	U.S.A		6. AGE (IN YEARS LAST BIRTHDAY)		80	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		BALTO. CITY MD.	
10. Baltimore		Melchior Nursing Home				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
						Housewife &		box work.	
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS	
MD				BALTO.				115 N. Bradford Street	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO		17. INFORMANT	
MICHAEL		SEEBERGER		MARY MARGARET		Leonard			
18. CAUSE OF DEATH		18. CAUSE OF DEATH		18. CAUSE OF DEATH		18. CAUSE OF DEATH		18. CAUSE OF DEATH	
PART I. DEATH WAS CAUSED BY:		PART I. DEATH WAS CAUSED BY:		PART I. DEATH WAS CAUSED BY:		PART I. DEATH WAS CAUSED BY:		PART I. DEATH WAS CAUSED BY:	
IMMEDIATE CAUSE (a)		IMMEDIATE CAUSE (a)		IMMEDIATE CAUSE (a)		IMMEDIATE CAUSE (a)		IMMEDIATE CAUSE (a)	
4292		4292		4292		4292		4292	
DUE TO, OR AS A CONSEQUENCE OF		DUE TO, OR AS A CONSEQUENCE OF		DUE TO, OR AS A CONSEQUENCE OF		DUE TO, OR AS A CONSEQUENCE OF		DUE TO, OR AS A CONSEQUENCE OF	
Arteriosclerotic Cardiovascular Disease		Arteriosclerotic Cardiovascular Disease		Arteriosclerotic Cardiovascular Disease		Arteriosclerotic Cardiovascular Disease		Arteriosclerotic Cardiovascular Disease	
DUE TO, OR AS A CONSEQUENCE OF		DUE TO, OR AS A CONSEQUENCE OF		DUE TO, OR AS A CONSEQUENCE OF		DUE TO, OR AS A CONSEQUENCE OF		DUE TO, OR AS A CONSEQUENCE OF	
Diabetes Mellitus, Urinary Tract Infection		Diabetes Mellitus, Urinary Tract Infection		Diabetes Mellitus, Urinary Tract Infection		Diabetes Mellitus, Urinary Tract Infection		Diabetes Mellitus, Urinary Tract Infection	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		20c. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (the hospital) attended the deceased from May 17, 1978, to Dec. 20, 1979, that (I) (we) lost saw the deceased alive on Dec. 18, 1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.		22b. SIGNATURE Loy M. Zimmerman MD		22c. DATE SIGNED 12/20/79					
22b. SIGNATURE		22c. DATE SIGNED		22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS		22f. ADDRESS	
				Loy M. Zimmerman MD		3202 Harford Rd, Baltimore			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE		23e. DATE REC'D. BY REGISTRAR	
Burial		12-24-1979		Holy Redeemer		BALTO. MD		DEC. 26 1979	
24. FUNERAL DIRECTOR		24b. ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		25c. DATE REC'D. BY REGISTRAR	
North M. L.		2334 Jefferson St.		DEC. 26 1979		P. J. H. H. H.			



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

7 9 3 0 2 9 7  
REG. NO.

FOR  
1 - STATE  
REGISTRAR

1 DECEASED NAME (TYPE OR PRINT) <b>Elroy Joseph Kunsky</b>			2a. DATE OF DEATH MONTH <b>December</b> DAY <b>12</b> YEAR <b>1979</b>		2b. HOUR <b>M</b>
3. SEX <b>Male</b>	4. RACE <b>Caucasian</b>	5. DATE OF BIRTH MONTH <b>June</b> DAY <b>26</b> YEAR <b>1906</b>	6. AGE (IN YEARS LAST BIRTHDAY) <b>73</b> YRS.	IF UNDER 1 YEAR MONTHS <b></b> DAYS <b></b>	IF UNDER 24 HRS HOURS <b></b> MIN. <b></b>
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.		
10. CITY OR TOWN OF DEATH <b>Baltimore</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>507 S. Linwood Ave</b>	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Ret.</b>		12b. KIND OF BUSINESS OR INDUSTRY <b></b>	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>MD</b> 13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Baltimore</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS <b>507 S. Linwood Ave</b>	
14. FATHER'S NAME FIRST <b>Joseph</b> MIDDLE <b></b> LAST <b>Kunsky</b>		15. MOTHER'S MAIDEN NAME FIRST <b>Sannie</b> MIDDLE <b>Michael</b> LAST <b></b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES OR UNKNOWN) <b>No</b>	16b. SOCIAL SECURITY NO. <b></b>	17. INFORMANT <b>Margaret Kunsky</b>		ADDRESS <b>507 S. Linwood</b>	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiopulmonary Arrest</b> <b>185-</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		DUE TO, OR AS A CONSEQUENCE OF <b>Metastatic Prostatic Carcinoma</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b></b>	
		DUE TO, OR AS A CONSEQUENCE OF <b></b>			
		DUE TO, OR AS A CONSEQUENCE OF <b></b>			

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): <b></b>					
19a. DATE OF OPERATION <b></b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b></b>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b></b> P.M. <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) <b></b>	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) <b></b>		21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b></b>	
22a. I certify that (I) (this hospital) attended the deceased from <b>12/16</b> , 19 <b>79</b> , to <b>DEC 12</b> , 19 <b>79</b> , that (I) (we) last saw the deceased alive on <b>12/12</b> , 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>Samantha L. Elmore</b>		DEGREE <b>ATTENDING PHYSICIAN</b> <input checked="" type="checkbox"/> <b>MEDICAL DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYSICIAN</b> <input type="checkbox"/>		22c. DATE SIGNED <b>12/14/79</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>BAYANI B. ELMAK</b>		22e. ADDRESS <b>3023 Eastern Ave Balti Md 21224</b>			
23a. BURIAL, CREMATION REMOVAL (IF BY) <b>Burial</b>		23b. DATE <b>12-15-79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Oak Lawn Cem</b>	
23d. LOCATION (CITY OR TOWN) <b>Baltimore Co., Md.</b>		23e. COUNTY <b></b>		23f. STATE <b></b>	
24. FUNERAL DIRECTOR NAME <b>Thelma A. Hoffman</b>		ADDRESS <b>3218 Hudson St.</b>		25a. DATE REC'D. BY REGISTRAR <b>DEC 18 1979</b>	
				25b. REGISTRAR'S SIGNATURE <b>notary</b>	

3500  
3500  
3000  
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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PM 3. RETAIN PAGE 3 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITH THE RECORDS, AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

Items #10a-22a Film G539 1/25/80 STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										3 0 2 9 8 REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) <b>JEANNETTE SHIRLEY KUSHNER</b>										2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR <b>12 1 19 79</b>	
3. SEX <b>female</b>		4. RACE <b>white</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>JUNE 12, 1922</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>57 YRS.</b>		IF UNDER 1 YR. MONTHS DAYS		2c. DATE PRONOUNCED DEAD MONTH DAY YEAR <b>12 1 19 79</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MARYLAND</b>				7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.	
10. CITY OR TOWN OF DEATH <b>Baltimore</b>				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Sinai Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>SECY./RECEPT.</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>MEDICAL</b>	
13a. STATE <b>MARYLAND</b>				13b. COUNTY		13c. CITY OR TOWN <b>BALTIMORE</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>7048 SURREY DR., 1ST FL. 21215</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>SAMUEL KOLKER</b>						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>FANNIE UNKNOWN</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>NO</b>				16b. SOCIAL SECURITY NO. <b>215-24-3147</b>		17. INFORMANT <b>MRS. MICHELE MAURER</b> <b>190 GRISWOLD CT. #B, RENO, NEV. 89503</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: <b>4292</b> IMMEDIATE CAUSE (a) <b>Arteriosclerotic cardiovascular disease</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost: (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <b>Margarita A. Korell</b>				TITLE (SPECIFY) <b>Assistant</b>				DATE SIGNED <b>12/2/79</b>			
EXAMINER'S NAME (TYPE OR PRINT) <b>Margarita A. Korell, M.D.</b>				ADDRESS <b>111 Penn Street</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>				23b. DATE <b>DEC. 3, 1979</b>		23c. NAME OF CEMETERY OR CREMATORY <b>HEBREW YOUNG MEN</b>				23d. LOCATION CITY OR TOWN COUNTY STATE <b>BALTIMORE MARYLAND</b>	
24. FUNERAL DIRECTOR <b>SOL LEVINSON &amp; BROS., INC.</b> <b>6010 REISTERSTOWN RD. BALTO., MD 21215</b>						25a. DATE REC'D. BY REGISTRAR <b>DEC 5 1979</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. For deaths occurring in the hospital, the certificate should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		7 9 3 0 2 9 9		REG. NO.					
1. DECEASED NAME (TYPE OR PRINT) Margaret K. Kuti				2a. DATE OF DEATH December 8, 1979		2b. HOUR 8:00p M			
3 SEX FEMALE		4 RACE WHITE		5 DATE OF BIRTH DEC. 12, 1907		6 AGE (IN YEARS (LAST BIRTHDAY)) 71 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.			
10 CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Maryland General Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) SALESLADY		12b. KIND OF BUSINESS OR INDUSTRY RETAIL	
13a. STATE MARYLAND		13b. COUNTY BALTIMORE		13c. CITY OR TOWN BALTIMORE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 5103 LINDEN HEIGHTS AVE. 21215	
14 FATHER'S NAME THOMAS BOENZLI				15 MOTHER'S MAIDEN NAME ALBERTA SNYDER					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO				16b. SOCIAL SECURITY NO. 212-05-9632A		17 INFORMANT MRS. JULIUS JESS KUTI 5103 LINDEN HTS. AVE., BALTO., MD 21215			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22 I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>12/2/79</u> to <u>12/8/79</u> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>12/8/79</u> , and that in <input checked="" type="checkbox"/> (my) (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) did <input checked="" type="checkbox"/> view the body after death.									
22b. SIGNATURE Harvey S. Mishner M.D.				DEGREE M.D.		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 12/8/79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Harvey Mishner, M.D.				22e. ADDRESS c/o 827 Linden Ave. Balto. MD 21201					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE DEC. 11, 1979		23c. NAME OF CEMETERY OR CREMATORY HEBREW YOUNG MEN		23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE MARYLAND			
24 FUNERAL DIRECTOR SOL LEVINSON & BROS., INC. 6010 REISTERSTOWN RD. BALTO., MD 21215						25a. DATE REC'D. BY REGISTRAR DEC 13 1979		25b. REGISTRAR'S SIGNATURE [Signature]	

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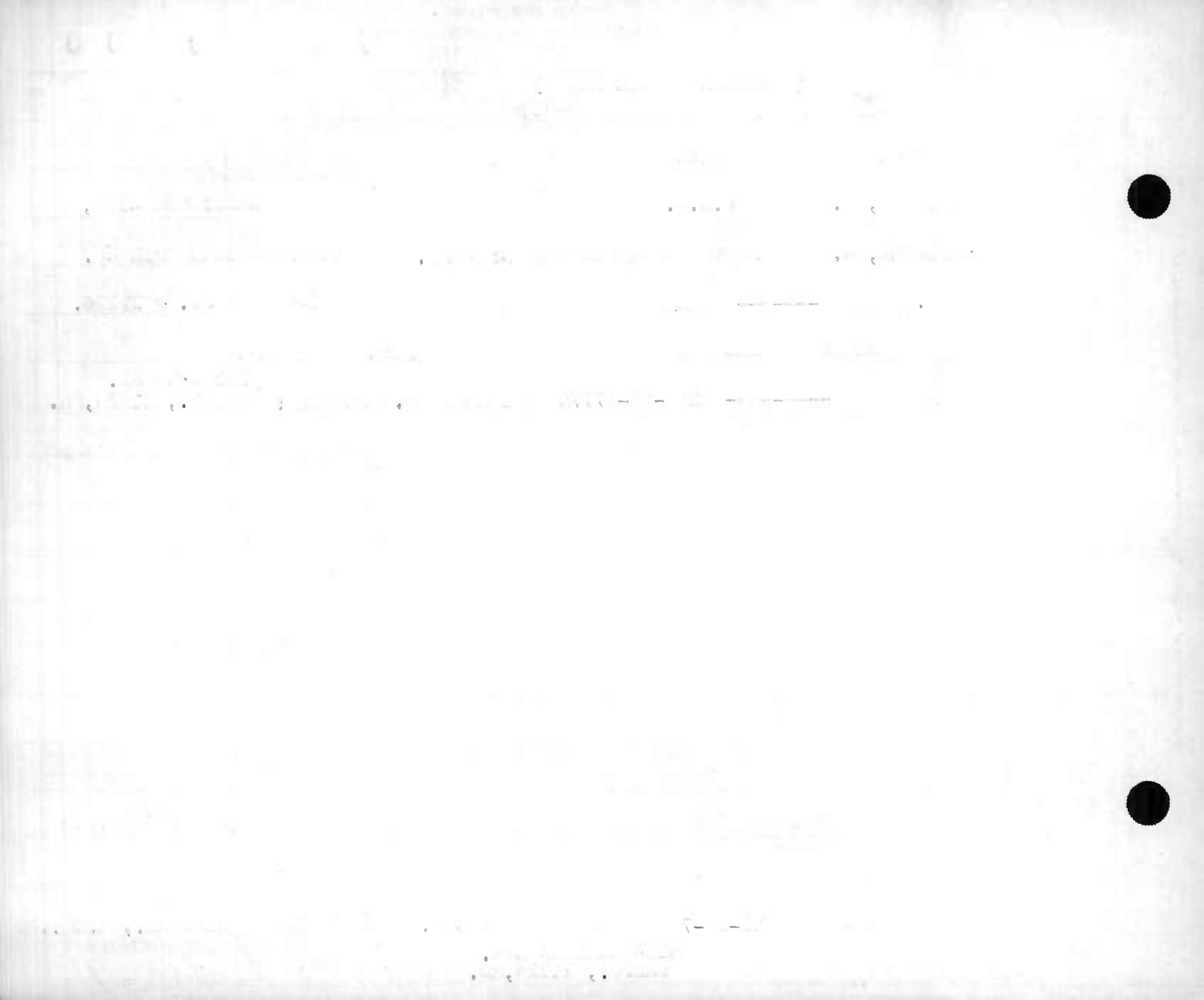


TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR					7 9 3 0 3 0 0 REG. NO.				
1. DECEASED NAME (TYPE OR PRINT) FIRST (EDWARD) MIDDLE (LACHNER) LAST (LACHNER)					2a. DATE OF DEATH MONTH DAY YEAR 12-17-79			2b. HOUR 8:10 A.M.	
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR 10-2-04		6. AGE (IN YEARS LAST BIRTHDAY) 75 YRS		7. IF UNDER 1 YEAR IF UNDER 24 HRS MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) BALTIMORE, MD.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY, MD.			
10. CITY OR TOWN OF DEATH BALTIMORE, MD.		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SOUTH BALTIMORE GENERAL HOSP.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) EXXON RETIRED		12b. KIND OF BUSINESS OR INDUSTRY EXXON OIL CO.	
13a. STATE MD.		13b. COUNTY		13c. CITY OR TOWN BALTIMORE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 302 DREW ST. # 21224.	
14. FATHER'S NAME FIRST MIDDLE LAST SAMUEL LACHNER					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST LENA WLEGAND				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 215-05-9777A		17. INFORMANT ADDRESS ELIZABETH M. LACHNER, 302 DREW ST. BALTO., 21224, MD.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cordiac arrest, possible myocardial infarction 436- DUE TO, OR AS A CONSEQUENCE OF (b) Sepsis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } DUE TO, OR AS A CONSEQUENCE OF (c) cerebrovascular accident APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 days									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 12/17 19 79, to 12/17 19 79, that (I) (we) lost saw the deceased alive on 12/17 19 79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Steven Rapp			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 12/17/79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) STEVEN RAPP					22e. ADDRESS 3001 S. HANOVER ST.				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE 12-20-79		23c. NAME OF CEMETERY OR CREMATORY SACRED HEART CEM.		23d. LOCATION CITY OR TOWN COUNTY STATE 7401 GERMAN HILL RD. BA. CO., MD.		
24. FUNERAL DIRECTOR NAME Charles S. Geiler & Son, Inc. 6224 EASTERN AVE. BALTO., 21224, MD.					25a. DATE REC'D. BY REGISTRAR DEC 20 1979		25b. REGISTRAR'S SIGNATURE		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1 - FOR STATE REGISTRAR			REG. NO. 9 30301						
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR P M
James Lamb						12-10-79			125 P M
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY) YRS.		IF UNDER 1 YEAR MONTHS DAYS	
MALE		BLACK		08-25-13		66			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			
North Carolina		U. S. A.				Baltimore MD.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Baltimore		Mercy Hospital							
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
Maryland					Baltimore		13e. STREET ADDRESS		
							716 Washington Place Apt-410		
14. FATHER'S NAME FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST						
Press Faison			Lucy Lamb						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS				
No			237-18-1183		Clarissa Williams Three Oaks Road				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>cardiopulmonary arrest</u>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
1619 } DUE TO, OR AS A CONSEQUENCE OF (b) <u>probable sepsis</u>									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } DUE TO, OR AS A CONSEQUENCE OF (c) <u>malignant mesothelioma</u>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>laryngeal cancer, old CVA</u>									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M.		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
			19						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (1) <u>this hospital</u> attended the deceased from <u>11-10</u> , 19 <u>79</u> , to <u>12-10</u> , 19 <u>79</u> , that (1) <u>we</u> lost saw the deceased alive on <u>12-10</u> , 19 <u>79</u> , and that in <u>my</u> (our) opinion death occurred on the date and hour and from the causes stated above, (1) <u>we</u> (did) (did not) view the body after death.									
22b. SIGNATURE			DEGREE			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED	
Kathleen H. Miller, MD								12-10-79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS						
Kathleen H. Miller			Mercy Hospital						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE			
Burial		12/14/1979		King Memorial Park		Baltimore Co., Maryland			
24. FUNERAL DIRECTOR NAME			ADDRESS			25. DATE REC'D. BY REGISTRAR		REGISTRAR'S SIGNATURE	
Wm. C. March F/H 1101 East North Avenue						DEC 11 1979		[Signature]	



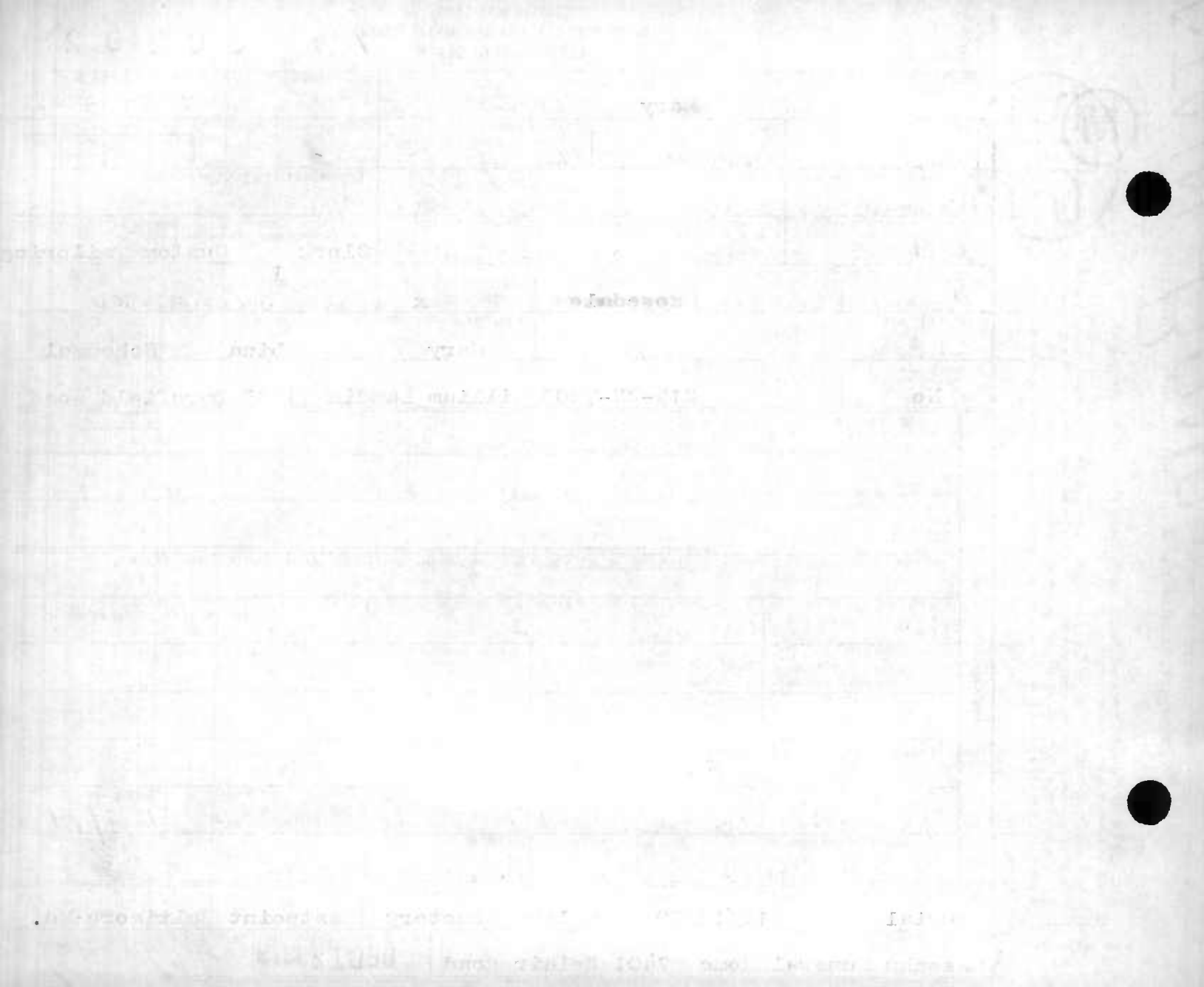
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Post retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										
1. FOR STATE REGISTRAR		7 9 3 0 3 0 2 REG. NO.								
1. DECEASED NAME (TYPE OR PRINT) <b>DOROTHY Mary LAMDIN</b>					2a. DATE OF DEATH MONTH DAY YEAR <b>12 9 79</b>					2b. HOUR <b>4:00 P.M.</b>
3 SEX <b>FEMALE</b>		4 RACE <b>CAUCASIAN</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>12 12 25</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>53</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MARYLAND</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY</b> MD.				
10 CITY OR TOWN OF DEATH <b>BALTIMORE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>UNIVERSITY HOSPITAL</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Clerk</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Custom Tailoring</b>		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
13a. STATE <b>MARYLAND</b>		13b. COUNTY <b>BALTIMORE</b>		13c. CITY OR TOWN <b>Rosedale</b>		13e. STREET ADDRESS <b>1625 BURNFIELD RD.</b>				
14 FATHER'S NAME FIRST MIDDLE LAST <b>Adam GERLACH</b>					15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Marv Sabina Schemmel</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (IF YES, NO OR UNKNOWN) <input checked="" type="checkbox"/> No		16b. SOCIAL SECURITY NO. <b>219-22-7205</b>		17 INFORMANT ADDRESS <b>William Lamdin 1625 Burnfield Road</b>						
18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Electrolyte IMBALANCE</b> <b>1749</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Metastatic breast cancer</b> DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
19a. DATE OF OPERATION <b>1974</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Left breast Cancer</b>				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from <b>Dec 2</b> , 19 <b>79</b> , to <b>Dec 9</b> , 19 <b>79</b> , that (I) (we) last saw the deceased alive on <b>Dec 19</b> , 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <b>Louis H. Cohen</b>				DEGREE <b>MD.</b> ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c. DATE SIGNED <b>12/9/79</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>LOUIS H. COHEN</b>				22e. ADDRESS <b>MD UNIVERSITY HOSPITAL</b>						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>12/12/79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Oaklawn Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Eastpoint Baltimore Md.</b>				
24 FUNERAL DIRECTOR NAME <b>Lassahn Funeral Home</b>				ADDRESS <b>7401 Belair Road</b>		25a. DATE REC'D. BY REGISTRAR <b>DEC 12 1979</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>		



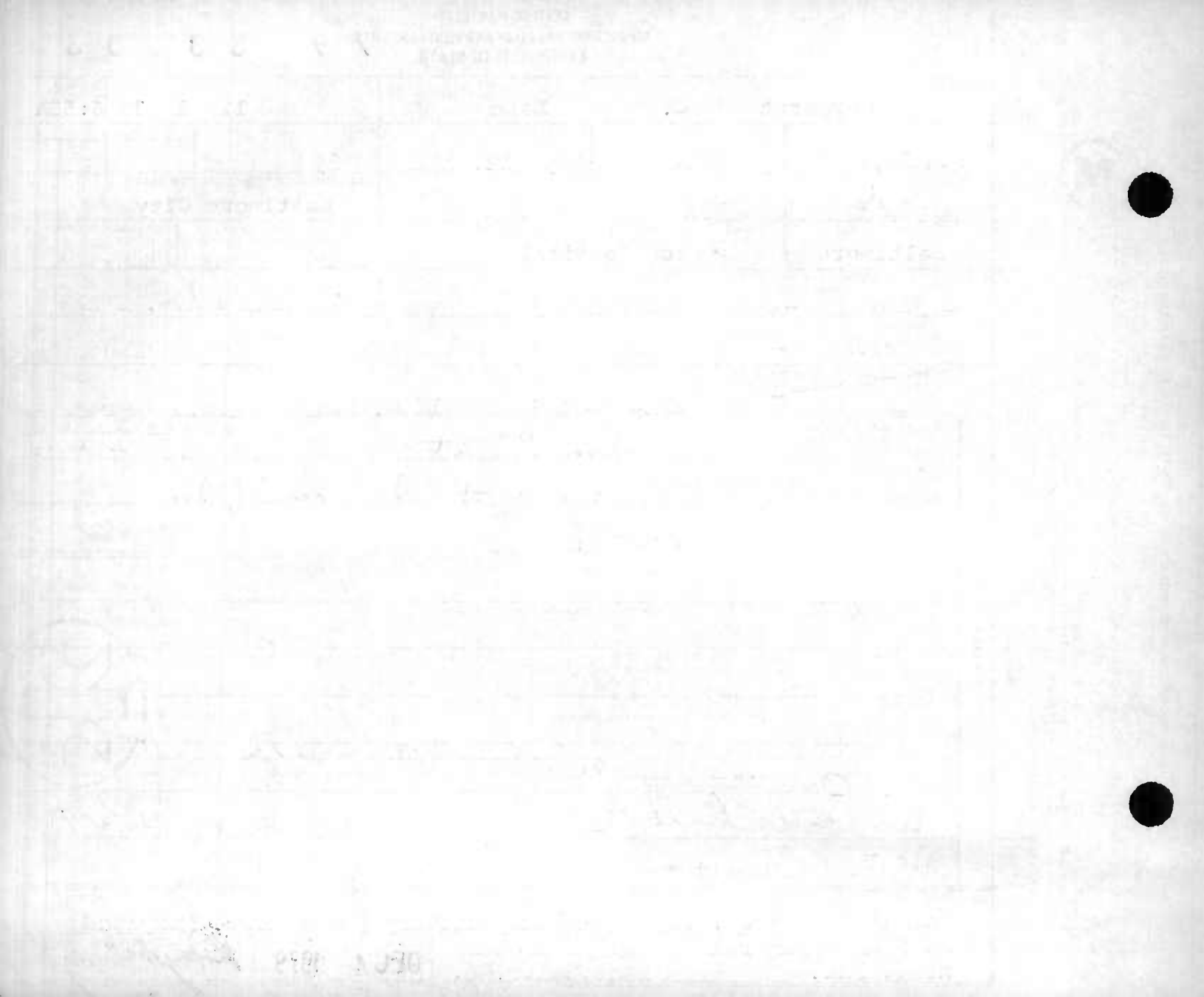
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director on page 3, should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of the death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR			7 9 3 0 3 0 3 REG. NO.						
1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Margaret C. Lang						2a. DATE OF DEATH MONTH DAY YEAR 12 3 79		2b. HOUR 6:53A M	
3 SEX Female		4 RACE White		5 DATE OF BIRTH MONTH DAY YEAR May 22, 1914		6 AGE (IN YEARS LAST BIRTHDAY) 65 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.			
10 CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Mercy Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Clerk		12b. KIND OF BUSINESS OR INDUSTRY Bank	
13a. STATE Maryland		13b. COUNTY -		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 3911 Elmora Ave. 21213	
14 FATHER'S NAME FIRST MIDDLE LAST Patrick - Lang				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Katherine Lane					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 212-07-8627		17 INFORMANT Ronald G. Lang		ADDRESS same address			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cancer Arrest</u> 4392 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Congestive Heart Failure, Renal failure</u> (c) <u>ASCVD</u> DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 hours									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>11/26</u> , 19 <u>79</u> , to <u>12/3</u> , 19 <u>79</u> , that (I) (we) last saw the deceased alive on <u>12/3</u> , 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE W. Fred Obrecht M.D.				DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 12/3/79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) W. Fred Obrecht				22e. ADDRESS Mercy Hosp.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Dec. 6, 1979		23c. NAME OF CEMETERY OR CREMATORY Oaklawn Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Maryland			
24. FUNERAL DIRECTOR NAME Grumnek Funeral Home, Inc.				ADDRESS 3331 Brehms Lane, Balto. Md.		25a. DATE REC'D. BY REGISTRAR DEC 4 1979		25b. REGISTRAR'S SIGNATURE [Signature]	

MEDICAL CERTIFICATION





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed within 72 hours after death. The medical examiner must be notified at once.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

7 9 3 0 3 0 4  
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>CHARLES A. LANGUTH</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>12 08 79</b>			2b. HOUR <b>12:30am</b>			
3. SEX <b>MALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>12 - 17 - 04</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>74</b> YRS.		7. IF UNDER 1 YEAR MONTHS DAYS <b>00 00</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MARYLAND</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City, MD.</b>			
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>VAMC, 3900 Loch Raven Blvd 21218</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Labrnl</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Labrnl</b>	
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Baltimore</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>1110 Scott Street 21230</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Charles Languth</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Hattie Hohn</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b>		16b. SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES) <b>WWII 218038170 A</b>		17. INFORMANT ADDRESS <b>VAMC, Medical Records 3900 Loch Raven Blvd</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>CARDIAC ARRHYTHMIA-SINUS BRADYCARDIA/</b> <b>1419</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>VENTRICULAR QUADRIGEMINY</b> <b>SQUAMOUS CELL CARCINOMA OF TONGUE</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>WITH METASTASES</b>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (1) (this hospital) attended the deceased from <b>NOVEMBER 12</b> 19 <b>79</b> to <b>DECEMBER 8</b> 19 <b>79</b> , that (1) (we) saw the deceased alive on <b>DECEMBER 8</b> 19 <b>79</b> , and that in (1) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>Susan T. Strahan M.D.</b>				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c. DATE SIGNED <b>12-8-79</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>SUSAN T. STRAHAN M.D.</b>				22e. ADDRESS <b>3900 Loch Raven Blvd 21218</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>12-11-79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Glen Haven</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Glen Burnie Ind.</b>			
24. FUNERAL DIRECTOR <b>John Brown, Jr. 901 Hallway St.</b>				25a. REC'D. BY REGISTRAR <b>12-23</b>		25b. REGISTRAR'S SIGNATURE <b>John Brown</b>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		7 9 3 0 3 0 5 REG. NO.							
1. DECEASED NAME (TYPE OR PRINT)		FIRST ROBIN		MIDDLE LA		LAST RUE		2. DATE OF DEATH MONTH DAY YEAR 12-24-79	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 1 20 54		6. AGE (IN YEARS LAST BIRTHDAY) 25		7. HOUR 4:50pm	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City		10. MD.	
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Church Home Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Printer		12b. KIND OF BUSINESS OR INDUSTRY Printing	
13a. STATE Md.		13b. COUNTY Baltimore		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 405 S. Eden Street	
14. FATHER'S NAME FIRST MIDDLE LAST Leo E. LaRue		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Alice Waltman							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) Unknown		17. INFORMANT Alice Baines, 407 S. Eden Street Baltimore, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>EXTENSIVE BILATERAL PNEUMONIA</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>ASPIRATION DURING PERIOD OF COMA</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>COMA DUE TO AN OVERDOSE OF DORIDEN</u>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
3041 CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST									
19. OTHER FACTORS OR CONDITIONS CONTRIBUTING TO DEATH BUT NOT PRESENT TO THE MEDICAL EXAMINER OR CONDITIONS GIVEN IN PART I <u>RESPIRATORY FAILURE (2) TO BILATERAL EXTENSIVE PNEUMONIA, BILATERAL PNEUMOTHORAX, SUBCUTANEOUS EMPHYSEMA</u>									
20. DATE OF OPERATION 12-17-79 and 12-20-79		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 12-15-79 to 12-24-79, that (I) (we) lost saw the deceased alive on 12-24-79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) did (did not) view the body after death.)									
22b. SIGNATURE A. F. Nour		DEGREE MD		22c. DATE SIGNED 12-24-79					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DR. A. F. NOUR		22e. ADDRESS CHURCH HOSPITAL CORPORATION 100 N. BROADWAY, BALTIMORE MARYLAND 31							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12-27-79		23c. NAME OF CEMETERY OR CREMATORY Moreland Memorial Park		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Baltimore Md.			
24. FUNERAL DIRECTOR Nicholas T. Matthews, 3021 Eastern Avenue Baltimore, Md.				25a. DATE REC'D. BY REGISTRAR DEC 27 1979		25b. REGISTRAR'S SIGNATURE D. J. Kelly			

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LA RITE

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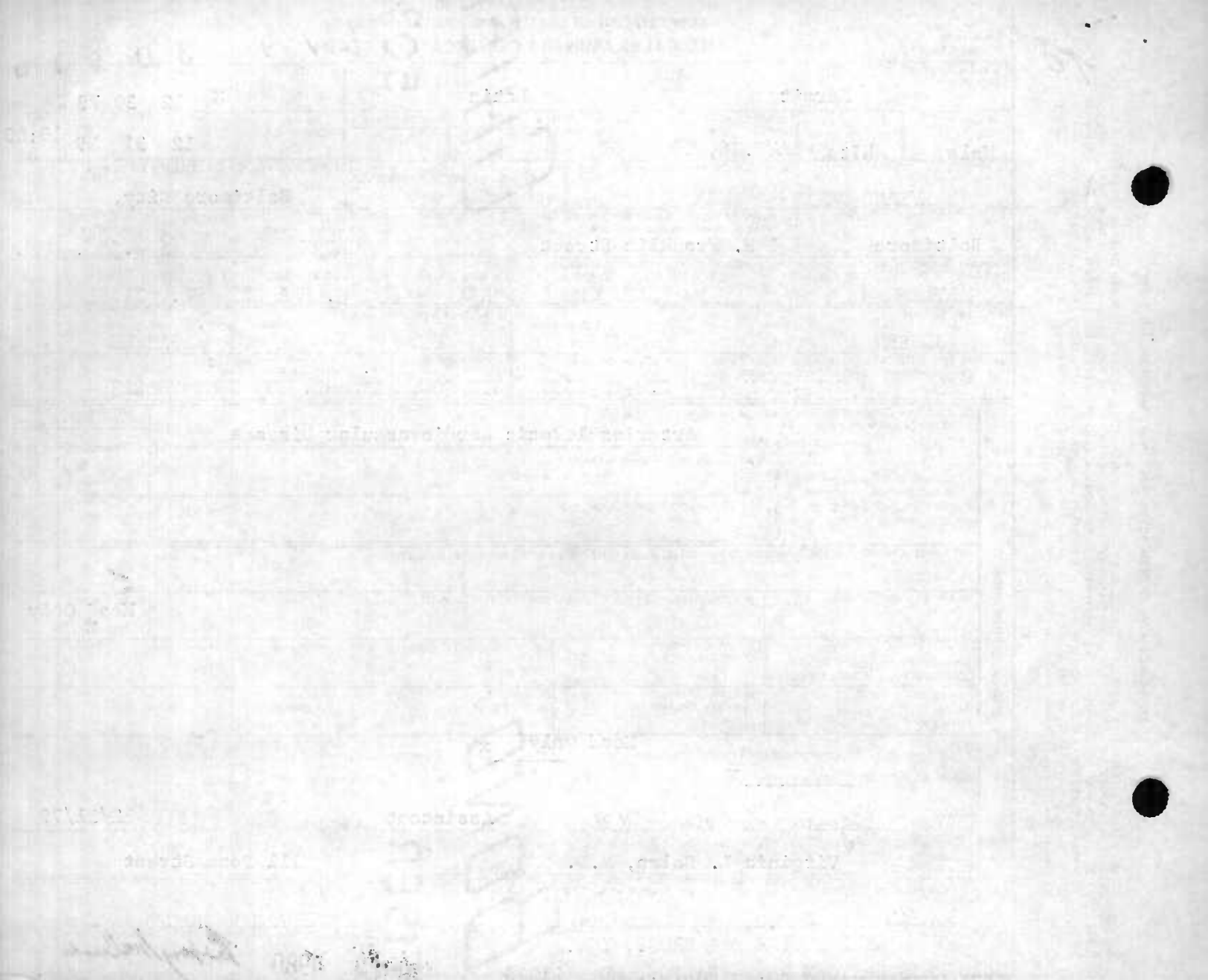
LA RITE  
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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING," IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF, MEDICAL EXAMINER, ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										9 REG. NO. 30306	
1. DECEASED NAME (TYPE OR PRINT) <b>Kermit</b>				MIDDLE <b>Latin</b>				LAST		2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> 12 30 79	
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>AUG. 26, 1917</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>62</b> YRS.		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MARYLAND</b>				7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		2c. DATE PRONOUNCED DEAD MONTH DAY YEAR <b>12 31 79</b>	
10. CITY OR TOWN OF DEATH <b>Baltimore</b>				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>1 W. Franklin Street</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>CLERK</b>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City, MD.</b>	
13a. STATE <b>MARYLAND</b>				13b. COUNTY <b>BALTIMORE</b>		13c. CITY OR TOWN <b>BALTIMORE</b>		13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		13e. STREET ADDRESS <b>1 W. FRANKLIN ST. #21201</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>JOSEPH</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>ETTA GASSER</b>				16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>YES</b>			
16b. SOCIAL SECURITY NO. <b>WWII-ARMY</b>				17. INFORMANT <b>MRS. ANNETTE RUBIN</b>				17. ADDRESS <b>312 SOUTHWIND RD., TOWSON, MD 21204</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic Cardiovascular Disease</b> 4292 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ (c) _____ DUE TO, OR AS A CONSEQUENCE OF										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? <b>Head Only</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22. I certify that I took charge of the remains described above, held on <u>Autopsy</u> <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <i>Virginia L. Dolan</i>				TITLE (SPECIFY) <b>Assistant</b>				DATE SIGNED <b>12/31/79</b>			
EXAMINER'S NAME (TYPE OR PRINT) <b>Virginia L. Dolan, M.D.</b>				ADDRESS <b>111 Penn Street</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>				23b. DATE <b>JAN. 2, 1980</b>				23c. NAME OF CEMETERY OR CREMATORY <b>MARYLAND LODGE</b>			
24. FUNERAL DIRECTOR NAME <b>SOL LEVINSON &amp; BROS., INC.</b>				25a. DATE REC'D. BY REGISTRAR <b>JAN 3 1980</b>				25b. REGISTRAR'S SIGNATURE <i>Ricky Helms</i>			
6010 REISTERSTOWN RD. BALTO., MD 21215				ROSEDALE BALTO. MD							





TD HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR STATE REGISTRAR		STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH		7 9 3 0 3 0 7 REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) Bertha Mave, Mave Lawhorn BERTHA MAVE LAWHORN			2a. DATE OF DEATH MONTH DAY YEAR 12-26-79		2b. HOUR 8:58pm
3 SEX Female	4 RACE White	5. DATE OF BIRTH MONTH DAY YEAR Nov. 25, 1895	6 AGE (IN YEARS LAST BIRTHDAY) 84 YRS.	7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN IF UNDER 24 HRS HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) West Virginia	7b. CITIZEN OF WHAT COUNTRY? U. S. A.	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD		
10 CITY OR TOWN OF DEATH Baltimore	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Church Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker	12b. KIND OF BUSINESS OR INDUSTRY Own Home	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland			13b. CITY OR TOWN Baltimore	13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13d. STREET ADDRESS 1933 Eastern Ave.
14 FATHER'S NAME FIRST MIDDLE LAST James Highlander			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Burns		
16a. WAS DECEASED EVER IN U. S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 220-24-1443	17 INFORMANT ADDRESS William F. Lawhorn, Same As #13e		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c): PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIO RESPIRATORY <del>INFACTION</del> ARREST</b> 410- DUE TO, OR AS A CONSEQUENCE OF (b) <b>PROBABLE MYOCARDIAL INFARCTION</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): (1) DEHYDRATION (2) skin DECUBITI					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital attended the deceased from 12-26-1979, to 12-26-1979, that (I) we lost saw the deceased alive on 12-26-1979, and that in my opinion death occurred on the date and hour and from the causes stated above, (b) (c) (d) (e) (f) (g) (h) (i) (j) (k) (l) (m) (n) (o) (p) (q) (r) (s) (t) (u) (v) (w) (x) (y) (z) (aa) (ab) (ac) (ad) (ae) (af) (ag) (ah) (ai) (aj) (ak) (al) (am) (an) (ao) (ap) (aq) (ar) (as) (at) (au) (av) (aw) (ax) (ay) (az) (ba) (bb) (bc) (bd) (be) (bf) (bg) (bh) (bi) (bj) (bk) (bl) (bm) (bn) (bo) (bp) (bq) (br) (bs) (bt) (bu) (bv) (bw) (bx) (by) (bz) (ca) (cb) (cc) (cd) (ce) (cf) (cg) (ch) (ci) (cj) (ck) (cl) (cm) (cn) (co) (cp) (cq) (cr) (cs) (ct) (cu) (cv) (cw) (cx) (cy) (cz) (da) (db) (dc) (dd) (de) (df) (dg) (dh) (di) (dj) (dk) (dl) (dm) (dn) (do) (dp) (dq) (dr) (ds) (dt) (du) (dv) (dw) (dx) (dy) (dz) (ea) (eb) (ec) (ed) (ee) (ef) (eg) (eh) (ei) (ej) (ek) (el) (em) (en) (eo) (ep) (eq) (er) (es) (et) (eu) (ev) (ew) (ex) (ey) (ez) (fa) (fb) (fc) (fd) (fe) (ff) (fg) (fh) (fi) (fj) (fk) (fl) (fm) (fn) (fo) (fp) (fq) (fr) (fs) (ft) (fu) (fv) (fw) (fx) (fy) (fz) (ga) (gb) (gc) (gd) (ge) (gf) (gg) (gh) (gi) (gj) (gk) (gl) (gm) (gn) (go) (gp) (gq) (gr) (gs) (gt) (gu) (gv) (gw) (gx) (gy) (gz) (ha) (hb) (hc) (hd) (he) (hf) (hg) (hh) (hi) (hj) (hk) (hl) (hm) (hn) (ho) (hp) (hq) (hr) (hs) (ht) (hu) (hv) (hw) (hx) (hy) (hz) (ia) (ib) (ic) (id) (ie) (if) (ig) (ih) (ii) (ij) (ik) (il) (im) (in) (io) (ip) (iq) (ir) (is) (it) (iu) (iv) (iw) (ix) (iy) (iz) (ja) (jb) (jc) (jd) (je) (jf) (jg) (jh) (ji) (jj) (jk) (jl) (jm) (jn) (jo) (jp) (jq) (jr) (js) (jt) (ju) (jv) (jw) (jx) (jy) (jz) (ka) (kb) (kc) (kd) (ke) (kf) (kg) (kh) (ki) (kj) (kk) (kl) (km) (kn) (ko) (kp) (kq) (kr) (ks) (kt) (ku) (kv) (kw) (kx) (ky) (kz) (la) (lb) (lc) (ld) (le) (lf) (lg) (lh) (li) (lj) (lk) (ll) (lm) (ln) (lo) (lp) (lq) (lr) (ls) (lt) (lu) (lv) (lw) (lx) (ly) (lz) (ma) (mb) (mc) (md) (me) (mf) (mg) (mh) (mi) (mj) (mk) (ml) (mn) (mo) (mp) (mq) (mr) (ms) (mt) (mu) (mv) (mw) (mx) (my) (mz) (na) (nb) (nc) (nd) (ne) (nf) (ng) (nh) (ni) (nj) (nk) (nl) (nm) (nn) (no) (np) (nq) (nr) (ns) (nt) (nu) (nv) (nw) (nx) (ny) (nz) (oa) (ob) (oc) (od) (oe) (of) (og) (oh) (oi) (oj) (ok) (ol) (om) (on) (oo) (op) (oq) (or) (os) (ot) (ou) (ov) (ow) (ox) (oy) (oz) (pa) (pb) (pc) (pd) (pe) (pf) (pg) (ph) (pi) (pj) (pk) (pl) (pm) (pn) (po) (pp) (pq) (pr) (ps) (pt) (pu) (pv) (pw) (px) (py) (pz) (qa) (qb) (qc) (qd) (qe) (qf) (qg) (qh) (qi) (qj) (qk) (ql) (qm) (qn) (qo) (qp) (qq) (qr) (qs) (qt) (qu) (qv) (qw) (qx) (qy) (qz) (ra) (rb) (rc) (rd) (re) (rf) (rg) (rh) (ri) (rj) (rk) (rl) (rm) (rn) (ro) (rp) (rq) (rr) (rs) (rt) (ru) (rv) (rw) (rx) (ry) (rz) (sa) (sb) (sc) (sd) (se) (sf) (sg) (sh) (si) (sj) (sk) (sl) (sm) (sn) (so) (sp) (sq) (sr) (ss) (st) (su) (sv) (sw) (sx) (sy) (sz) (ta) (tb) (tc) (td) (te) (tf) (tg) (th) (ti) (tj) (tk) (tl) (tm) (tn) (to) (tp) (tq) (tr) (ts) (tt) (tu) (tv) (tw) (tx) (ty) (tz) (ua) (ub) (uc) (ud) (ue) (uf) (ug) (uh) (ui) (uj) (uk) (ul) (um) (un) (uo) (up) (uq) (ur) (us) (ut) (uu) (uv) (uw) (ux) (uy) (uz) (va) (vb) (vc) (vd) (ve) (vf) (vg) (vh) (vi) (vj) (vk) (vl) (vm) (vn) (vo) (vp) (vq) (vr) (vs) (vt) (vu) (vv) (vw) (vx) (vy) (vz) (wa) (wb) (wc) (wd) (we) (wf) (wg) (wh) (wi) (wj) (wk) (wl) (wm) (wn) (wo) (wp) (wq) (wr) (ws) (wt) (wu) (wv) (ww) (wx) (wy) (wz) (xa) (xb) (xc) (xd) (xe) (xf) (xg) (xh) (xi) (xj) (xk) (xl) (xm) (xn) (xo) (xp) (xq) (xr) (xs) (xt) (xu) (xv) (xw) (xx) (xy) (xz) (ya) (yb) (yc) (yd) (ye) (yf) (yg) (yh) (yi) (yj) (yk) (yl) (ym) (yn) (yo) (yp) (yq) (yr) (ys) (yt) (yu) (yv) (yw) (yx) (yy) (yz) (za) (zb) (zc) (zd) (ze) (zf) (zg) (zh) (zi) (zj) (zk) (zl) (zm) (zn) (zo) (zp) (zq) (zr) (zs) (zt) (zu) (zv) (zw) (zx) (zy) (zz)					
22b. SIGNATURE EDWARD SCHUSTER		DEGREE in MD		22c. ADDRESS CHURCH HOSPITAL CORPORATION 100 N. BROADWAY BALTIMORE, MARYLAND 31	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12-30-79	23c. NAME OF CEMETERY OR CREMATORY Hner Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Lewisburg Greenbrier West Va.
24 FUNERAL DIRECTOR NAME Ruck Towson Funeral Home, Inc. Towson, Md. 21204		ADDRESS 1050 York Rd.		25a. DATE REC'D. BY REGISTRAR DEC 28 1979	25b. REGISTRAR'S SIGNATURE [Signature]

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DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>LYNWOOD PEARCH LAWRENCE</b>			2a. DATE OF DEATH MONTH <b>12</b> DAY <b>24</b> YEAR <b>79</b>		2b. HOUR <b>7:15 AM</b>
3. SEX <b>MALE</b>	4. RACE <b>WHITE</b>	5. DATE OF BIRTH MONTH <b>1</b> DAY <b>22</b> YEAR <b>14</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>65</b> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MARYLAND</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY</b> MD.	
10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>3900 LOCH RAVEN BLVD., BALTO. MD.</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>STEEL WORKER</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>ARMCO</b>
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>MARYLAND</b>			13b. COUNTY	13c. CITY OR TOWN <b>BALTO.</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST <b>UNKNOWN</b> MIDDLE LAST			15. MOTHER'S MAIDEN NAME FIRST <b>HALIE</b> MIDDLE LAST <b>WHITE</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES OR UNKNOWN) <b>YES</b>		16b. SOCIAL SECURITY NO. <b>WW 11</b>		17. INFORMANT ADDRESS <b>JESSIE LAWRENCE (WIFE) SAME ADDRESS</b>	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u> 410 - DUE TO, OR AS A CONSEQUENCE OF (b) <u>Probable Myocardial Infarction</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost DUE TO, OR AS A CONSEQUENCE OF (c) <u>Hypertension</u>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Diffuse Pneumonia of Undetermined Etiology</u>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET <b>VAMC, LOCH RAVEN BLVD., BALTO. MD.</b> CITY OR TOWN <b>BALTO.</b> COUNTY <b>MD.</b> ZIP <b>21218</b>	
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>Dec 23</u> , 19 <u>79</u> , to <u>Dec 24</u> , 19 <u>79</u> , that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on <u>Dec 23</u> , 19 <u>79</u> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input type="checkbox"/> (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>Elliott Friedman, MD</u>				22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Elliott Friedman</u>				22e. ADDRESS <u>Loch Raven V.A. Hospital</u>	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>12/28/79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Baltimore</b>	
23d. LOCATION CITY OR TOWN <b>Balto.</b> COUNTY <b>Md.</b>					
24. FUNERAL DIRECTOR <b>Schimmek Funeral Home, Inc.</b>		24b. ADDRESS <b>3331 Brehms Lane Balto. Md. 21213</b>		25a. DATE REC'D. BY REGISTRAR <b>DEC 28 1979</b>	
25b. REGISTRAR'S SIGNATURE <u>Rafaela K. Cuddy</u>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40	41	42	43	44	45	46	47	48	49	50	51	52	53	54	55	56	57	58	59	60	61	62	63	64	65	66	67	68	69	70	71	72	73	74	75	76	77	78	79	80	81	82	83	84	85	86	87	88	89	90	91	92	93	94	95	96	97	98	99	100
101	102	103	104	105	106	107	108	109	110	111	112	113	114	115	116	117	118	119	120	121	122	123	124	125	126	127	128	129	130	131	132	133	134	135	136	137	138	139	140	141	142	143	144	145	146	147	148	149	150	151	152	153	154	155	156	157	158	159	160	161	162	163	164	165	166	167	168	169	170	171	172	173	174	175	176	177	178	179	180	181	182	183	184	185	186	187	188	189	190	191	192	193	194	195	196	197	198	199	200
201	202	203	204	205	206	207	208	209	210	211	212	213	214	215	216	217	218	219	220	221	222	223	224	225	226	227	228	229	230	231	232	233	234	235	236	237	238	239	240	241	242	243	244	245	246	247	248	249	250	251	252	253	254	255	256	257	258	259	260	261	262	263	264	265	266	267	268	269	270	271	272	273	274	275	276	277	278	279	280	281	282	283	284	285	286	287	288	289	290	291	292	293	294	295	296	297	298	299	300
301	302	303	304	305	306	307	308	309	310	311	312	313	314	315	316	317	318	319	320	321	322	323	324	325	326	327	328	329	330	331	332	333	334	335	336	337	338	339	340	341	342	343	344	345	346	347	348	349	350	351	352	353	354	355	356	357	358	359	360	361	362	363	364	365	366	367	368	369	370	371	372	373	374	375	376	377	378	379	380	381	382	383	384	385	386	387	388	389	390	391	392	393	394	395	396	397	398	399	400
401	402	403	404	405	406	407	408	409	410	411	412	413	414	415	416	417	418	419	420	421	422	423	424	425	426	427	428	429	430	431	432	433	434	435	436	437	438	439	440	441	442	443	444	445	446	447	448	449	450	451	452	453	454	455	456	457	458	459	460	461	462	463	464	465	466	467	468	469	470	471	472	473	474	475	476	477	478	479	480	481	482	483	484	485	486	487	488	489	490	491	492	493	494	495	496	497	498	499	500
501	502	503	504	505	506	507	508	509	510	511	512	513	514	515	516	517	518	519	520	521	522	523	524	525	526	527	528	529	530	531	532	533	534	535	536	537	538	539	540	541	542	543	544	545	546	547	548	549	550	551	552	553	554	555	556	557	558	559	560	561	562	563	564	565	566	567	568	569	570	571	572	573	574	575	576	577	578	579	580	581	582	583	584	585	586	587	588	589	590	591	592	593	594	595	596	597	598	599	600
601	602	603	604	605	606	607	608	609	610	611	612	613	614	615	616	617	618	619	620	621	622	623	624	625	626	627	628	629	630	631	632	633	634	635	636	637	638	639	640	641	642	643	644	645	646	647	648	649	650	651	652	653	654	655	656	657	658	659	660	661	662	663	664	665	666	667	668	669	670	671	672	673	674	675	676	677	678	679	680	681	682	683	684	685	686	687	688	689	690	691	692	693	694	695	696	697	698	699	700
701	702	703	704	705	706	707	708	709	710	711	712	713	714	715	716	717	718	719	720	721	722	723	724	725	726	727	728	729	730	731	732	733	734	735	736	737	738	739	740	741	742	743	744	745	746	747	748	749	750	751	752	753	754	755	756	757	758	759	760	761	762	763	764	765	766	767	768	769	770	771	772	773	774	775	776	777	778	779	780	781	782	783	784	785	786	787	788	789	790	791	792	793	794	795	796	797	798	799	800
801	802	803	804	805	806	807	808	809	810	811	812	813	814	815	816	817	818	819	820	821	822	823	824	825	826	827	828	829	830	831	832	833	834	835	836	837	838	839	840	841	842	843	844	845	846	847	848	849	850	851	852	853	854	855	856	857	858	859	860	861	862	863	864	865	866	867	868	869	870	871	872	873	874	875	876	877	878	879	880	881	882	883	884	885	886	887	888	889	890	891	892	893	894	895	896	897	898	899	900
901	902	903	904	905	906	907	908	909	910	911	912	913	914	915	916	917	918	919	920	921	922	923	924	925	926	927	928	929	930	931	932	933	934	935	936	937	938	939	940	941	942	943	944	945	946	947	948	949	950	951	952	953	954	955	956	957	958	959	960	961	962	963	964	965	966	967	968	969	970	971	972	973	974	975	976	977	978	979	980	981	982	983	984	985	986	987	988	989	990	991	992	993	994	995	996	997	998	999	1000

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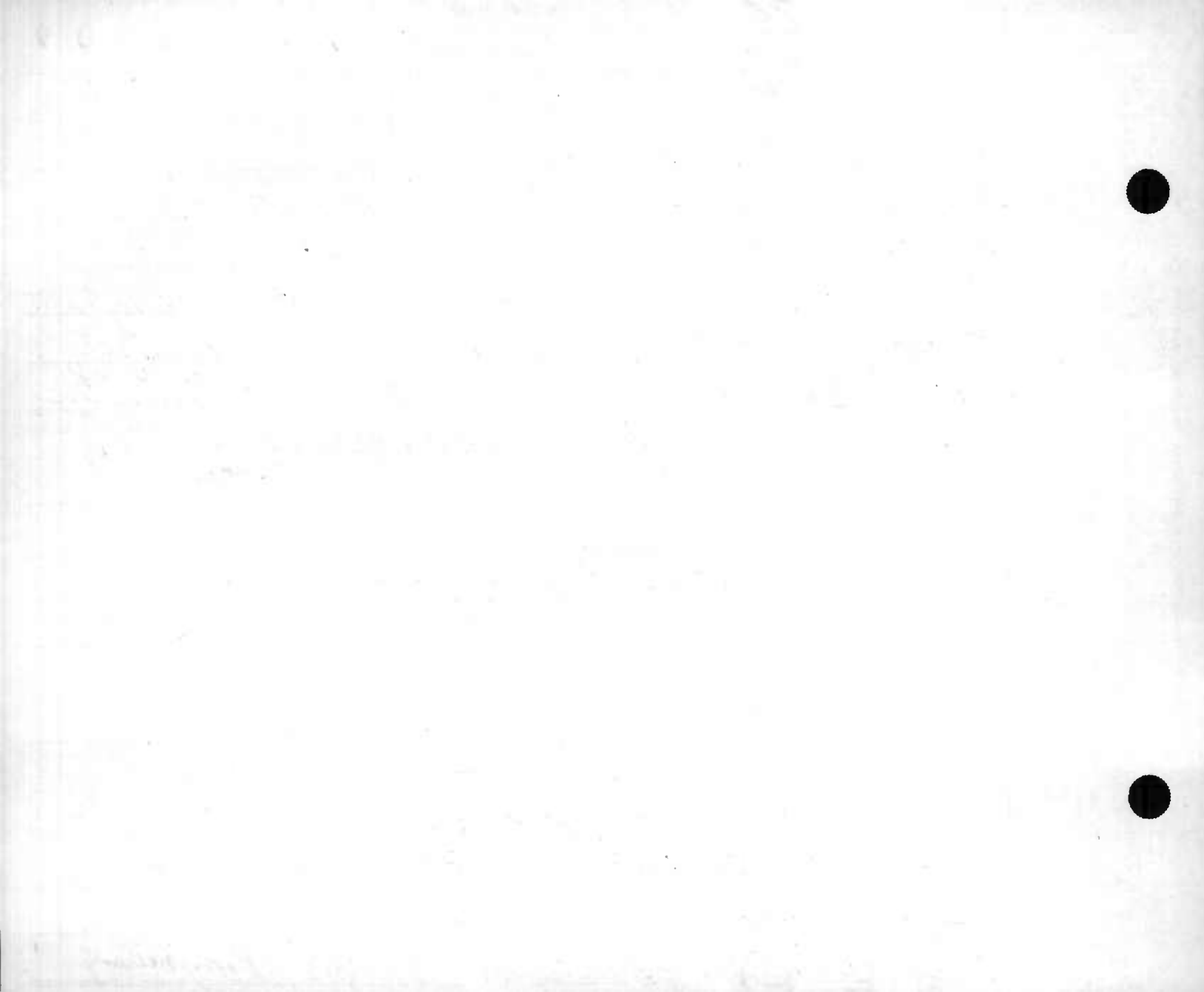
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR  
1- STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MARY MIDDLE L LAST LAWSON			2a. DATE OF DEATH MONTH 12 DAY 20 YEAR 79			2b. HOUR 9.10 AM			
3. SEX Female		4. RACE Negro		5. DATE OF BIRTH MONTH Nov DAY 5 YEAR 1924		6. AGE (IN YEARS LAST BIRTHDAY) 55 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Durham N.C.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Balto. city MD.			
10. CITY OR TOWN OF DEATH Balto.		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Bon Secours				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Catering		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE md 13b. COUNTY - 13c. CITY OR TOWN Balto.			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 1635 W. Lexington St				
14. FATHER'S NAME FIRST Emory MIDDLE LAST Stroud			15. MOTHER'S MAIDEN NAME FIRST Lona MIDDLE MASSEY LAST						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (IF YES, GIVE WAR OR DATES) No			16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS Balto. Md Lona Stroud - 45 Wheeler Ave				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>confluent bronchopneumonia, left lower lobe.</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>485-</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) <u>due to, or as a consequence of</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>days</u>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a): <u>Fatty metamorphosis of liver</u>									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) 12/16		21f. LOCATION STREET CITY OR TOWN COUNTY STATE 79 12/20 79				
22a. I certify that (I) (this hospital) attended the deceased from <u>12/20</u> , 19 <u>79</u> , to <u>12/20</u> , 19 <u>79</u> , that (I) (we) lost the deceased alive on <u>12/20</u> , 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Kuang-yen Huang			DEGREE M.D.			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 12/30/79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) KUANG-YEN HUANG			22e. ADDRESS BON Secours Hospital						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 12/24/79		23c. NAME OF CEMETERY OR CREMATORY Arbutusman Rd		23d. LOCATION CITY OR TOWN COUNTY STATE Balto. Md		
24. FUNERAL DIRECTOR NAME Jurnell B. Oden			ADDRESS Balto. Md			25a. DATE REC'D. BY REGISTRAR DEC 26 1979		25b. REGISTRAR'S SIGNATURE Patricia M. Brady	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of same.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										7 9 3 0 3 1 0	
1. FOR STATE REGISTRAR		REG. NO.									
1. DECEASED NAME (TYPE OR PRINT) <i>Walter P. Lawton</i>					2a. DATE OF DEATH MONTH DAY YEAR <i>Dec. 22, 1979</i>			2b. HOUR M <i>AM</i>			
3. SEX <i>Male</i>		4. RACE <i>White</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>July 4, 1900</i>		6. AGE (IN YEARS LAST BIRTHDAY) YRS <i>79</i>		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Maryland</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Baltimore City</i> MD.					
10. CITY OR TOWN OF DEATH <i>Baltimore</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>St. Agnes Hospital</i>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Electrician</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Beth. Steel</i>			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE 13b. COUNTY <i>Maryland V.A.A. Co.</i>		13c. CITY OR TOWN <i>Linthicum</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <i>10 Hampton Rd. Linthicum, Md.</i>					
14. FATHER'S NAME FIRST MIDDLE LAST <i>Jeremiah ----- Lawton</i>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Mary Elizabeth Boyd</i>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i>				16b. SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES) <i>216 10 4643</i>		17. INFORMANT ADDRESS <i>Mr. Boyd W. Lawton, Same as above</i>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Anoxia</i> <i>4140</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Cardiac Arrest</i> (c) <i>Arteriosclerotic Heart Disease</i>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <i>Hypertension</i>											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <i>4-5</i> , 19 <i>79</i> , to <i>12/22</i> , 19 <i>79</i> , that (I) (we) lost saw the deceased alive on <i>12/22</i> , 19 <i>79</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>Domingo C. Sorongon M.D.</i>						DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>DOMINGO C. SORONGON M.D.</i>						22e. ADDRESS <i>3915 HOLLINS FERRY RD 21227</i>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>Dec. 27, 1979</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Meadowridge Mem. Park</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Howard Co. Maryland</i>					
24. FUNERAL DIRECTOR NAME ADDRESS <i>McCully Funeral Home, 237 E. Patapsco Ave. Balto. Md.</i>						25a. DATE REC'D. BY REGISTRAR <i>DEC 28 1979</i>		25b. REGISTRAR'S SIGNATURE <i>Ruby McHenry</i>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										7 9 3 0 3 1 1			
1. FOR STATE REGISTRAR		REG. NO.											
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR
Dora		LAYFIELD		December 30,		1979		11:20					
3 SEX		4 RACE		5 DATE OF BIRTH		6 AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS			
Female		White		May 20, 1893		86 YRS.		MONTHS		DAYS		HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH							
Baltimore		U.S.A.				Baltimore City MD.							
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)								12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Baltimore		Church Hospital								Housewife			
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS					
Maryland				Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		627 S. Belnord Ave.					
14 FATHER'S NAME				15. MOTHER'S MAIDEN NAME									
FIRST MIDDLE LAST				FIRST MIDDLE LAST									
Oscar Eugene Giesebrech				Georgiana Tucker									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17 INFORMANT ADDRESS									
No		215-18-8388		Dorothy Layfield, 627 S. Belnord Ave.									
18 CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c.)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I DEATH WAS CAUSED BY:													
IMMEDIATE CAUSE (a) Cardiac Arrest													
DUE TO, OR AS A CONSEQUENCE OF													
4280 (b) Pulmonary Edema													
DUE TO, OR AS A CONSEQUENCE OF													
(c) Congestive Heart Failure													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)													
Fever and possible sepsis													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?					
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that (I) (this hospital) attended the deceased from Dec. 28, 1979m, to Dec. 30, 1979, that (I) (we) last saw the deceased alive on Dec. 30, 1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE		DEGREE						ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED			
Paul Gormely		MD								12/31/79			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS											
Paul Gormely M. D.		4607XXXXX Roland Ave Balto. Md.											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE							
Burial		1/3/80		Loudon Park Cemetery		Baltimore Maryland							
24 FUNERAL DIRECTOR NAME		ADDRESS						25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Lilly & Zeiler, Inc.		1901 Eastern Ave.						JAN 2 1980		[Signature]			

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Paul K. ...

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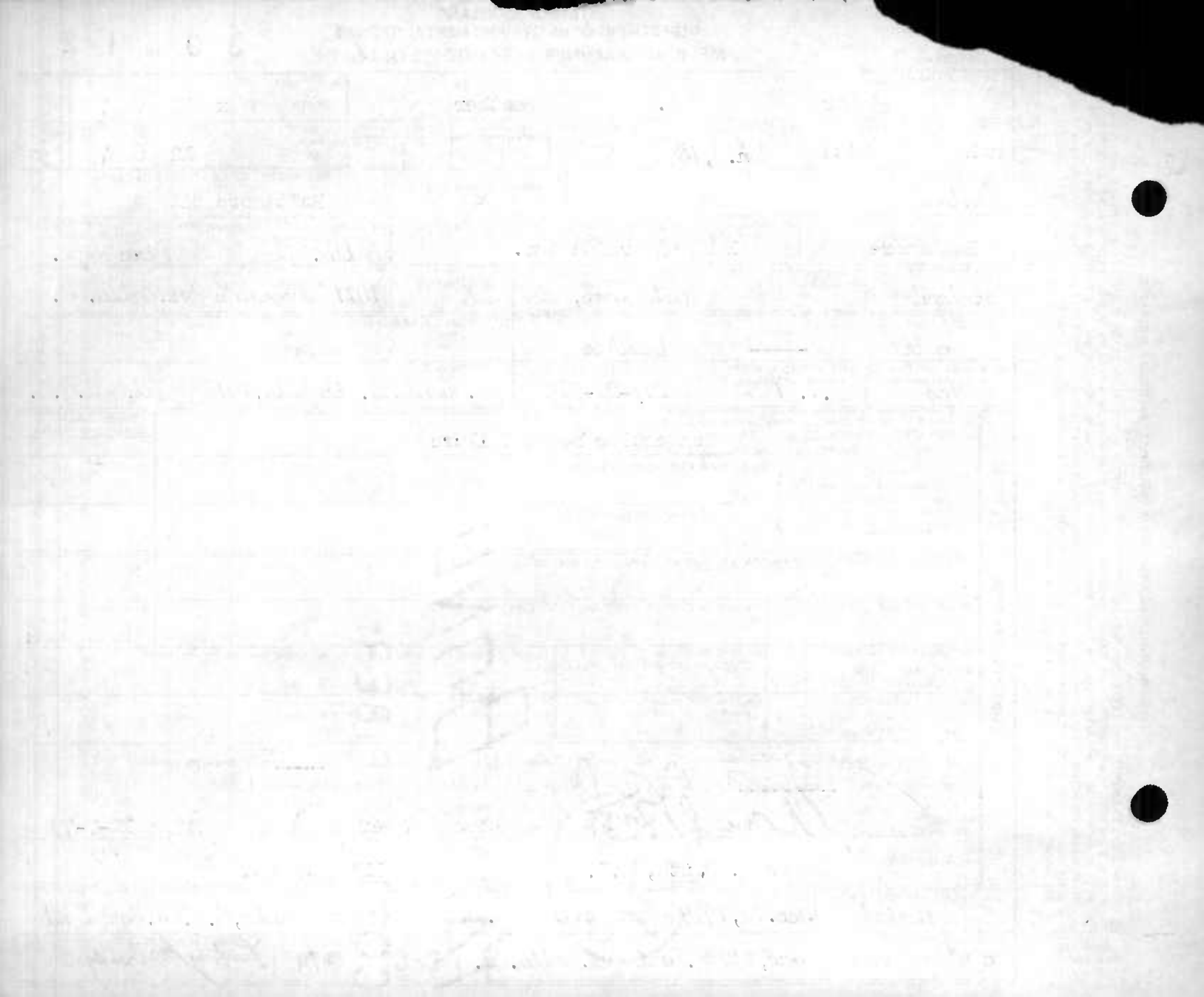
TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED. WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

30312

REGISTRAR		FIRST		MIDDLE		LAST		2a. DATE KNOWN OF DEATH		ESTIMATED		MONTH		DAY		YEAR		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		Mark		E.		Leather		12		6		19		79				M	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 1 YR		IF UNDER 24 HRS		2c. DATE PRONOUNCED DEAD		MONTH		DAY		YEAR	
male		white		Jan. 3, 1894		85 YRS.						12		6		1979		8:30 P M	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED		NEVER MARRIED		WIDOWED		DIVORCED		9. BALTIMORE CITY OR COUNTY OF DEATH							
Maryland		USA										Baltimore City MD.							
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY													
Baltimore		1011 Riverside Ave.		Balto. City		Fire Dept.													
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS											
Maryland				Baltimore,		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		1011 Riverside Ave. Balto. Md.											
14. FATHER'S NAME		MIDDLE		LAST		15. MOTHER'S MAIDEN NAME		FIRST		MIDDLE		LAST							
Scott				Leather		Unknown													
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS													
Yes		W.V. 1		217-22-7692		Mr. Donald J. Wienhold, 1010 Edgerly Rd. G.B.													
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)																		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I DEATH WAS CAUSED BY:																			
IMMEDIATE CAUSE (a) Congestive heart failure																			
4280																			
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.																			
(b)																			
DUE TO, OR AS A CONSEQUENCE OF																			
(c)																			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).																			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?																20. AUTOPSY?	
																		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)															
		HOUR A.M. MONTH DAY YEAR																	
		P.M. 19																	
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION		CITY OR TOWN		COUNTY		STATE									
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>																			
22a. I certify that I took charge of the remains described above, held in death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																			
Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion																			
TITLE (SPECIFY)																			
Deputy Chief																			
MEDICAL EXAMINER																			
DATE SIGNED																		12-7-79	
EXAMINER'S NAME (TYPE OR PRINT)		Thomas D. Smith, M.D.		ADDRESS		111 Penn St.													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (CITY OR TOWN)		COUNTY		STATE									
Burial		Dec. 10, 1979		Glen Haven Mem. Park		Glen Burnie, A.A.		Maryland											
24. FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE															
McCall Funeral Home, 130 E. Fort Ave. Balto. Md.		DEC 11 1979		Duffy McCreedy															



DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

79 30313

REG. NO.

FOR  
STATE  
REGISTRAR

1. DECEASED NAME (Type or Print) <b>ANNE Elizabeth</b>		FIRST <b>Lee</b>		LAST <b>Lee</b>		2a. DATE OF DEATH MONTH DAY YEAR <b>12 15 79</b>		2b. HOUR <b>7:51 PM</b>	
3. SEX <b>Female</b>		4. RACE <b>Black</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>2 15, 20</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>59</b> YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Virginia</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore</b> MD.			
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>BON Secour</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Baltimore</b>		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13d. STREET ADDRESS <b>19 S. Hilton Street</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>George Ghee</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Jennie Ewing</b>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)					
16b. SOCIAL SECURITY NO. <b>213-26-0595</b>		17. INFORMANT ADDRESS <b>Charles Lee 19 South Hilton St.</b>							
18. CAUSE OF DEATH (Enter only one cause per line for a), b), and c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac Arrest.</b> <b>4292</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>ASCVD &amp; Hypertension</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>10-12 yrs.</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>12-15-79</b>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>12-19-68</b> to <b>12-19-79</b> , that (I) (we) last saw the deceased alive on <b>12-19-79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>A-I. Baykaler, M.D.</b>		DEGREE <b>M.D.</b>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED <b>12-18-79</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>A-I. BAYKALER</b>		22e. ADDRESS <b>831 Poplar Grove St. Balt.</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>12/20/1979</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Baltimore Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore, Maryland</b>			
24. FUNERAL DIRECTOR NAME <b>Wm. C. March F/H 1101 East North Avenue</b>				ADDRESS <b>DEC 18 1979</b>		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE <b>Pistay Melnyk</b>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Please return it to the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 7 days of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of cause of death.



DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 30314

1. DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST	2b. DATE KNOWN OF DEATH		2c. DATE OF ESTI-MATED	MONTH	DAY	YEAR	2d. HOUR
GREGORY		V.		LEE	12 16 1979			12	16	1979	8:15 P.M.
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS)	IF UNDER 1 YR.		IF UNDER 24 HRS.		2e. DATE PRONOUNCED DEAD		
male	negro	7-5-57		22 YRS.					12 16 1979		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED		NEVER MARRIED		WIDOWED		DIVORCED	
Md.		U.S.A.								9. BALTIMORE CITY OR COUNTY OF DEATH	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY		
Baltimore		302 Bridgeview Rd.									
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS			
Md.				BALTO.		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		595 BAKER ST.			
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME							
FIRST MIDDLE LAST				FIRST MIDDLE LAST							
LORENZO				lee				Viola Bell			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES?				16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS			
(YES, NO, OR UNKNOWN)				(IF YES, GIVE WAR OR DATES)		213-70-0078		Viola lee Same			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											
PART I DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a) Hanging											
9530											
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.											
DUE TO, OR AS A CONSEQUENCE OF											
(b)											
DUE TO, OR AS A CONSEQUENCE OF											
(c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?			
								YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS				21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				HOUR A.M. MONTH DAY YEAR		Subject hanged self.					
				? P.M. 12-16-79							
21d. INJURY OCCURRED				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION		CITY OR TOWN		COUNTY STATE	
WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>				home		302 Bridgeview Rd.,		Balto.		Md.	
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE				TITLE (SPECIFY)				DATE SIGNED			
Ann M. Dixon, M.D.				M.D. Assistant				12-17-79			
EXAMINER'S NAME (TYPE OR PRINT)				ADDRESS							
				111 Penn St.							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION			
Burial				12-20-79		Mt. Auburn Cem.		BALTO., Md.			
24. FUNERAL DIRECTOR NAME				ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
VERNON Bailey				1348 CALHOUN ST.		DEC 18 1979		[Signature]			



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										30315 REG. NO.	
1. FOR STATE REGISTRAR											
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Lafayette Lee</b>										2a. DATE OF DEATH KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH DAY YEAR <b>12 24 1979</b>	
3. SEX <b>Male</b>		4. RACE <b>Black</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>2 3 01</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>78 YRS.</b>		IF UNDER 1 YR. MONTHS DAYS HOURS MIN		2b. HOUR <b>4:00 P M</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>N.C.</b>				7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		2c. DATE PRONOUNCED DEAD <b>12 24 1979</b>	
10. CITY OR TOWN OF DEATH <b>Baltimore</b>				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>2441 E. Hoffman Street</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE <b>MD.</b>		13b. COUNTY <b>N.E.</b>		13c. CITY OR TOWN <b>Balto.</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>2441 E. Hoffman St.</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>Unkn</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Unkn</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>No</b>				16b. SOCIAL SECURITY NO. <b>217-03-7739</b>		17. INFORMANT <b>Robert Ward</b>				ADDRESS <b>6640 Pioneer Dr.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: <b>4292 Arteriosclerotic Cardiovascular Disease</b> IMMEDIATE CAUSE (a) } DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. } (b) } DUE TO, OR AS A CONSEQUENCE OF (c) }										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE <i>Virginia L. Dolan</i>				TITLE (SPECIFY) <b>Assistant</b>				DATE SIGNED <b>12/25/79</b>			
EXAMINER'S NAME (TYPE OR PRINT) <b>Virginia L. Dolan, M.D.</b>				ADDRESS <b>111 Penn Street</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>				23b. DATE <b>12/29/79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Calvary Cem</b>				23d. LOCATION CITY OR TOWN COUNTY STATE <b>Anne Arundel Co. Md.</b>	
24. FUNERAL DIRECTOR NAME <b>Wm C March F/H</b>				ADDRESS <b>1101 E. North Ave.</b>				25a. DATE REC'D. BY REGISTRAR <b>DEC 26 1979</b>		25b. REGISTRAR'S SIGNATURE <i>Edith A. Brady</i>	



RECEIVED

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STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

7 9 3 0 3 1 6

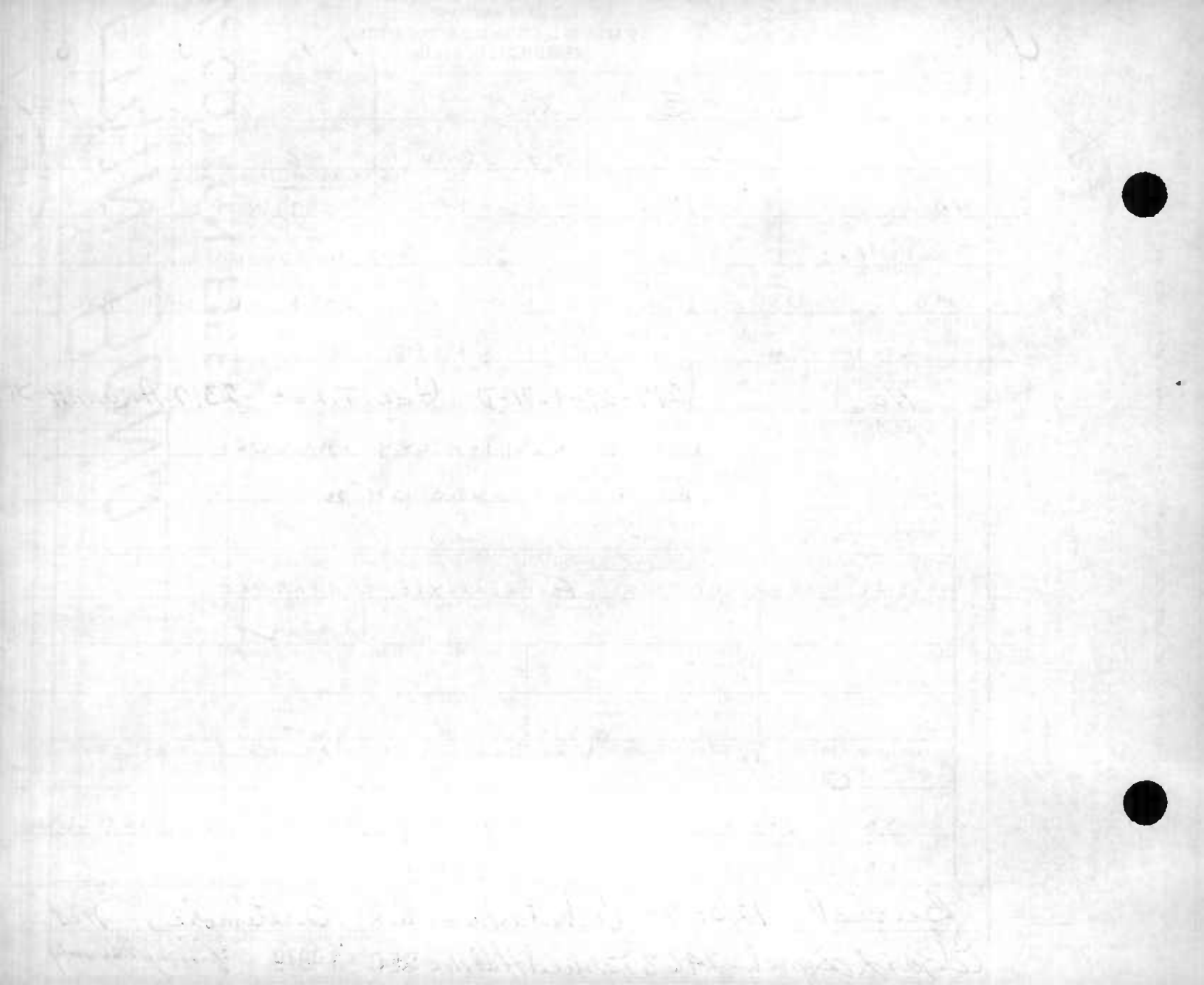
1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) LILLIAN E. LEE			2a. DATE OF DEATH MONTH DAY YEAR 12 02 79			2b. HOUR 9:30pm				
3. SEX F		4. RACE C		5. DATE OF BIRTH MONTH DAY YEAR 09 12 93		6. AGE (IN YEARS LAST BIRTHDAY) 86 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
8. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD		9. CITIZEN OF WHAT COUNTRY? USA		10. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		11. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.				
12. CITY OR TOWN OF DEATH BALTIMORE		13. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SBCGH				14. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSE WIFE		15. KIND OF BUSINESS OR INDUSTRY		
16. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 16a. STATE MD 16b. COUNTY USA 16c. CITY OR TOWN BALTIMORE 16d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> 16e. STREET ADDRESS 2317 ARUNAH AVE										
17. FATHER'S NAME FIRST MIDDLE LAST WOODS D HENRY				18. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST UNKNOWN						
19. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO				20. SOCIAL SECURITY NO. 217-07-4671-D		21. INFORMANT ADDRESS Geo. T. Lee - 2317 ARUNAH ST				
22. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIO RESPIRATORY FAILURE</u> 4151 DUE TO, OR AS A CONSEQUENCE OF (b) <u>PULMONARY EMBOLISM</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): <u>ATRIAL FIBRILLATION, ELECTROLYTE IMBALANCE</u>										
23a. DATE OF OPERATION			23b. CONDITION FOR WHICH OPERATION WAS PERFORMED			24a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		24b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
25a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			25b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			25c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
26a. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			26b. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) 12 NPM			26c. LOCATION STREET CITY OR TOWN COUNTY STATE				
27. I certify that (I) (this hospital) attended the deceased from 12/02/79, 9:30PM to 12/02/79, 9:30PM, and that (I) (we) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
28a. SIGNATURE J Dewipatel			28b. DEGREE MD			28c. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		28d. DATE SIGNED 12/02/79		
29a. PHYSICIAN'S NAME (TYPE OR PRINT) J DEVI PATEL			29b. ADDRESS SBCGH							
30a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			30b. DATE 12/08/79			30c. NAME OF CEMETERY OR CREMATORY Catholics Mem. Park			30d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Md	
31. FUNERAL DIRECTOR NAME Edward L. Lynch - 2463 Druid Hill Ave			31b. ADDRESS			32. DATE REC'D. BY REGISTRAR DEC 7 1979		33. REGISTRAR'S SIGNATURE Fitzroy Helmsley		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 3, 4, and 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										7 9 3 0 3 1 7 REG. NO.			
1. FOR STATE REGISTRAR						2a. DATE OF DEATH				MONTH DAY YEAR		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Janet S. Lehr						12 28 79				5 10 PM			
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS			
Female		White		MONTH DAY YEAR 2 27 1943		36 YRS.		MONTHS DAYS		HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH							
West Virginia		U.S.A.				Baltimore City MD.							
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY					
Baltimore		Baltimore City Hospitals				Nurses Aid		Jewish Home					
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)													
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS					
Maryland		Baltimore		Dundalk		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		1900 Tolson Avenue					
14. FATHER'S NAME FIRST MIDDLE LAST						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST							
Lindsey Ellington						Ernestine Terry							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)				16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS							
No				217-40-1977		Ernestine Ellington- Balto. MD 21222 2811 Creston Rd.							
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u> <u>0389</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Hypotension</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Sepsis</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): <u>Chronic Renal Failure; Acute Agnucleocytosis</u>													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
								YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <u>12/1</u> , 19 <u>79</u> , to <u>12/28</u> , 19 <u>79</u> , that (I) (we) lost saw the deceased alive on <u>12/28</u> , 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE <u>Arnold Falchuk</u>						DEGREE <u>MD</u>		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <u>1/28/79</u>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>ARNOLD FALCHUK</u>						22e. ADDRESS <u>Balt. City Hosp.</u>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE					
Burial				12/31/79		Holly Hill		White Marsh, Balto. MD					
24. FUNERAL DIRECTOR NAME <u>Duda-Ruck, Inc.</u>						24b. ADDRESS <u>7922 Wise Avenue, Dundalk, MD 21222</u>		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE <u>R. J. McCreedy</u>			
						JAN 3 1980							

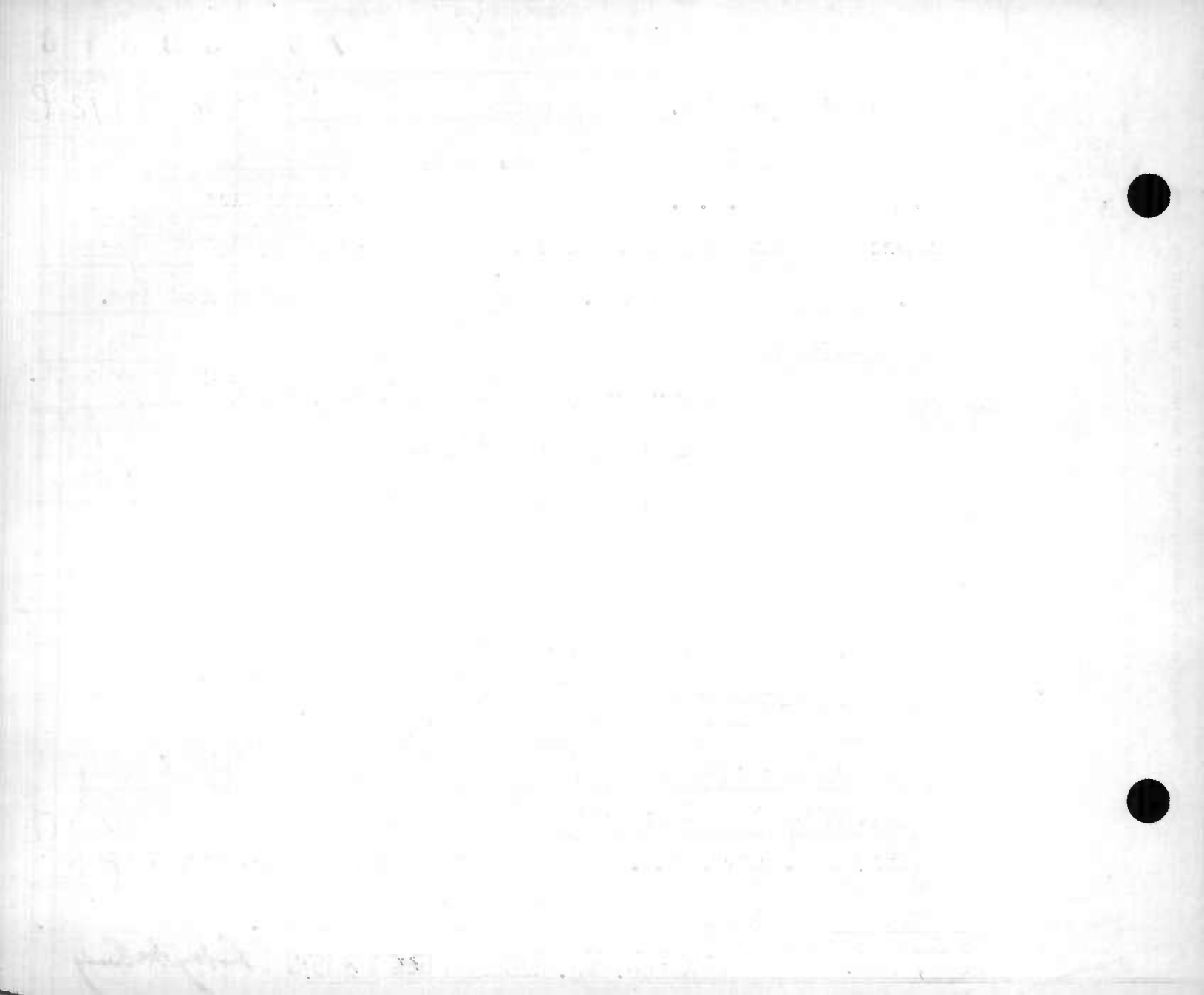


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
<div style="display: flex; justify-content: space-between;"> <div> <b>1- FOR STATE REGISTRAR</b>            1. DECEASED NAME (TYPE OR PRINT) <b>GEORGE W. Lennox</b> </div> <div> <b>7 9 3 0 3 1 8</b>            REG. NO.         </div> </div>									
2a. DATE OF DEATH			MONTH DAY YEAR			2b. HOUR			
			12 16 79			1222 PM			
3 SEX		4 RACE		5 DATE OF BIRTH		6 AGE (IN YEARS LAST BIRTHDAY)		7 IF UNDER 1 YEAR	
Male		White		May 27, 1901		78 YRS.		MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH			
Md.		U.S.A.				BALTIMORE CITY MD.			
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)							
BALTIMORE		UNION MEMORIAL HOSPITAL							
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY							
Truck Driver		Railroad							
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				13b. INSIDE CITY LIMITS?				13c. STREET ADDRESS	
13a. STATE				13b. COUNTY				13c. CITY OR TOWN	
Md.				Balto.				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14 FATHER'S NAME				15 MOTHER'S MAIDEN NAME					
FIRST MIDDLE LAST				FIRST MIDDLE LAST					
unknown				unknown					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17 INFORMANT		ADDRESS			
no		216-01-8313		Thelma Voelker (dghtr)		15 Treeway Ct.		21204	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									
PART I. DEATH WAS CAUSED BY:									
IMMEDIATE CAUSE (a) <u>Cardiogenic shock</u>									
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Myocardial infarction</u>									
DUE TO, OR AS A CONSEQUENCE OF (c) _____									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
OR CONTRIBUTING CAUSE OF DEATH		HOUR A.M. MONTH DAY YEAR							
		P.M. 19							
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION					
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>12/16/79</u> 19 <u>79</u> to <u>12/16/79</u> 19 <u>79</u> that (I) (we) last saw the deceased alive on <u>12/16/79</u> 19 <u>79</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) (did) (did not) view the body after death.									
22b. SIGNATURE		DEGREE				22c. DATE SIGNED			
<u>Gregory E. Faith, MD</u>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				12/16/79			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS							
GREGORY E. FAITH, M.D.		UNION MEMORIAL HOSPITAL							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION		23e. COUNTY	
Burial		12/19/79		Gardens of Faith		Balto.		Md.	
24. FUNERAL DIRECTOR		24b. ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Scammurek Funeral Home, Inc.		3331 Brehms Lane Balto. Md. 21213		DEC 18 1979		<u>Henry McLeod</u>			

BP



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

79 30319

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>HOWARD R. LEONARD</b>		2a. DATE OF DEATH MONTH DAY YEAR <b>DECEMBER 15, 1979</b>		2b. HOUR <b>9:05 P.M.</b>	
3 SEX <b>M</b>	4 RACE <b>W</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>5/10/24</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>55</b> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>PA.</b>	7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY</b> MD.	
10. CITY OR TOWN OF DEATH <b>BALTO</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>THE JOHNS HOPKINS HOSPITAL</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>AIR FORCE</b>		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE <b>MD.</b>		13b. COUNTY <b>BALTO</b>	13c. CITY OR TOWN <b>DUNDALK</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>HOWARD LEONARD</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>UNK</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>YES</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>213283073</b>		17. INFORMANT ADDRESS <b>SYDELLE LEONARD ABOVE</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <b>Respiratory Failure</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Heart Shutter Christian Dze</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Melancholia Carcinoma</b>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>12/1</b> , 19 <b>79</b> , to <b>12/15</b> , 19 <b>79</b> , that (I) (we) lost saw the deceased alive on <b>12/15</b> , 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>Robert Micht</b>		DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>12/15/79</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Robert Micht</b>		22e. ADDRESS <b>Johns Hopkins Hospital</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>12/19/79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>SACRED HEART</b>	
23d. LOCATION CITY OR TOWN COUNTY STATE <b>BALTO. MD</b>		24. FUNERAL DIRECTOR NAME <b>J.G. CONNELLY</b>		25a. DATE REC'D. BY REGISTRAR <b>DEC 20 1979</b>	
25b. REGISTRAR'S SIGNATURE <b>Larry Kelley</b>		25c. ADDRESS <b>300 MALE</b>			

BP

DHMH-16 25M  
(VRA 15, 4) 1/79TO HOSPITAL OR ATTENDING PHYSICIAN  
retained by the hospital or attending physician.TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,  
should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death  
with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION





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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled up by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of the death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH-16 25M  
(VRA 15, 4) 1/79

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 79 30320	
1. DECEASED NAME (TYPE OR PRINT) <sup>FIRST</sup> CATHRYN <sup>MIDDLE</sup> M <sup>LAST</sup> LEPPO			2a. DATE OF DEATH <sup>MONTH</sup> 12 <sup>DAY</sup> 26 <sup>YEAR</sup> 79		2b. HOUR <sup>MIN</sup> 3:10p <sup>M</sup>
3 SEX FEMALE	4 RACE WHITE	5 DATE OF BIRTH <sup>MONTH</sup> 10 <sup>DAY</sup> 5 <sup>YEAR</sup> 01	6 AGE (IN YEARS LAST BIRTHDAY) 78	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? USA	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9 BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.		
10 CITY OR TOWN OF DEATH Baltimore	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) ST. AGNES HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife	12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Maryland	13b. COUNTY Howard	13c. CITY OR TOWN Ellicott City	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS 4833 South Haven Drive 21043	
14 FATHER'S NAME <sup>FIRST</sup> late John <sup>MIDDLE</sup> Grogg <sup>LAST</sup>		15. MOTHER'S MAIDEN NAME <sup>FIRST</sup> late Elizabeth <sup>MIDDLE</sup> <sup>LAST</sup>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)	17 INFORMANT ADDRESS Mr Oney Leppo 4833 South Haven Drive			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Pseudomonas pneumonia</u> 496- DUE TO, OR AS A CONSEQUENCE OF (b) <u>Chronic obstructive pulmonary disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>Kareem Said</u>		DEGREE		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DR. KAREEM SAID		22e. ADDRESS 900 So. CATON AVE. BALTO MD 21229		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE Dec. 29, 1979	23c. NAME OF CEMETERY OR CREMATORY Greenmount		23d. LOCATION CITY OR TOWN	23e. STATE Carroll, Maryland
24 FUNERAL DIRECTOR NAME Harry H. Witzke		25. DATE REC'D BY REGISTRAR DEC 31 1979		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

Chemical constituents of the plant

Korean Ginseng

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH7 9 3 0 3 2 1  
REG. NO.1. FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>OSCAR</b>		FIRST		MIDDLE		LAST		2a. DATE OF DEATH		MONTH		DAY		YEAR		2b. HOUR	
						<b>LEVINE</b>		<b>DEC.</b>		<b>14</b>		<b>1979</b>		<b>12:50P</b>		<b>M</b>	
3. SEX <b>MALE</b>		4. RACE <b>Caucasian</b>		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS							
				<b>APRIL 18 1979</b>		<b>80</b>		MONTHS		DAYS		HOURS		MIN			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Balto.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY</b>											
10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>LEVINGALE HEBREW GERIATRIC HOSPITAL</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>MACHINIST</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>KOPPERS CO.</b>											
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13a. STATE <b>MARYLAND</b>		13b. COUNTY <b>BALTIMORE</b>		13c. CITY OR TOWN <b>BALTIMORE</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>4213 FORDS LA.</b>							
14. FATHER'S NAME FIRST <b>HYMAN</b>		MIDDLE		LAST <b>LEVINE</b>		15. MOTHER'S MAIDEN NAME FIRST <b>REBECCA</b>		MIDDLE		LAST <b>UNKNOWN</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>213-10-9065</b>		17. INFORMANT <b>IRVIN LEVINE</b>		ADDRESS <b>4121 CRESTHEIGHTS RD.</b>										<b>BALTO., MD 21215</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: <b>436- Cerebrovascular Accident</b>		IMMEDIATE CAUSE (a)		DUE TO, OR AS A CONSEQUENCE OF												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>3 WKS</b>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last				(b)		DUE TO, OR AS A CONSEQUENCE OF											
				(c)													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)											
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE											
22a. I certify that (this hospital) attended the deceased from <b>MAY 11 1976</b> to <b>DEC. 14 1979</b> , that (we) lost saw the deceased alive on <b>DEC. 14 1979</b> and that in (our) opinion death occurred on the date and hour and from the causes stated above, (we) did (not) view the body after death.																	
22b. SIGNATURE <b>Estrelita O. KU</b>		DEGREE						22c. DATE SIGNED <b>12/14/79</b>									
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS															
		<b>LEVINGALE HEBREW GERIATRIC HOSPITAL</b>															
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>DEC. 16, 1979</b>		23c. NAME OF CEMETERY OR CREMATORY <b>BETH ISAAC ADATH ISRAEL</b>				23d. LOCATION CITY OR TOWN COUNTY <b>BALTIMORE MARYLAND</b>									
24. FUNERAL DIRECTOR <b>SOL LEVINSON &amp; BROS., INC.</b> NAME ADDRESS <b>6010 REISTERSTOWN RD. BALTO., MD 21215</b>										25a. DATE REC'D. BY REGISTRAR <b>DEC 20 1979</b>		25b. REGISTRAR'S SIGNATURE <b>Richard McCreedy</b>					

MEDICAL CERTIFICATION

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
1- FOR STATE REGISTRAR		7 9 3 0 3 2 2		REG. NO.							
1. DECEASED NAME (TYPE OR PRINT)		FIRST FLORENCE		MIDDLE		LAST Levy		2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR	
3. SEX Female		4. RACE W		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR MONTHS DAYS		8. IF UNDER 74 HRS HOURS MIN.	
9. BIRTHPLACE (STATE OR FOREIGN COUNTRY) PA.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTO. CITY				MD.	
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Sinai Hosp. of Baltimore		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY					
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) MD		13b. COUNTY		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 5 Stonehenge Circle Apt 6			
14. FATHER'S NAME FIRST UNKNOWN		MIDDLE		LAST		15. MOTHER'S MAIDEN NAME FIRST		MIDDLE SHOLKIN		LAST	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 465-38-7408		17. INFORMANT NATHAN B. LEVY		ADDRESS SAME		21220			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cardiac & Resp. arrest											
1629 DUE TO, OR AS A CONSEQUENCE OF (b) Lung Cancer											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from 11-21-1979, to 12-1-1979, that (I) (we) lost saw the deceased alive on 12-1-1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Samy Bekawf		DEGREE MD		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 12-1-79					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) SAMY Bekawf		22e. ADDRESS Sinai Hosp. of Baltimore									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 12-4-79		23c. NAME OF CEMETERY OR CREMATORY Holy Cross Cem.		23d. LOCATION (CITY OR TOWN) Phil.		COUNTY PA.		STATE	
24. FUNERAL DIRECTOR NAME NEWELL F.H.		ADDRESS 1100 REISTERS TOWN RD		25a. DATE REC'D. BY REGISTRAR DEC 5 1979		25b. REGISTRAR'S SIGNATURE Anthony McCreedy					

BP

SECRET

1. The first part of the report deals with the general situation in the country. It is a very interesting and informative account of the current state of affairs. The author has done a great deal of research and has gathered a wealth of material. The report is well written and is easy to read. It is a valuable contribution to the study of the country.

2. The second part of the report deals with the economic situation. It is a very detailed and thorough account of the current state of the economy. The author has done a great deal of research and has gathered a wealth of material. The report is well written and is easy to read. It is a valuable contribution to the study of the country.

3. The third part of the report deals with the social situation. It is a very detailed and thorough account of the current state of society. The author has done a great deal of research and has gathered a wealth of material. The report is well written and is easy to read. It is a valuable contribution to the study of the country.

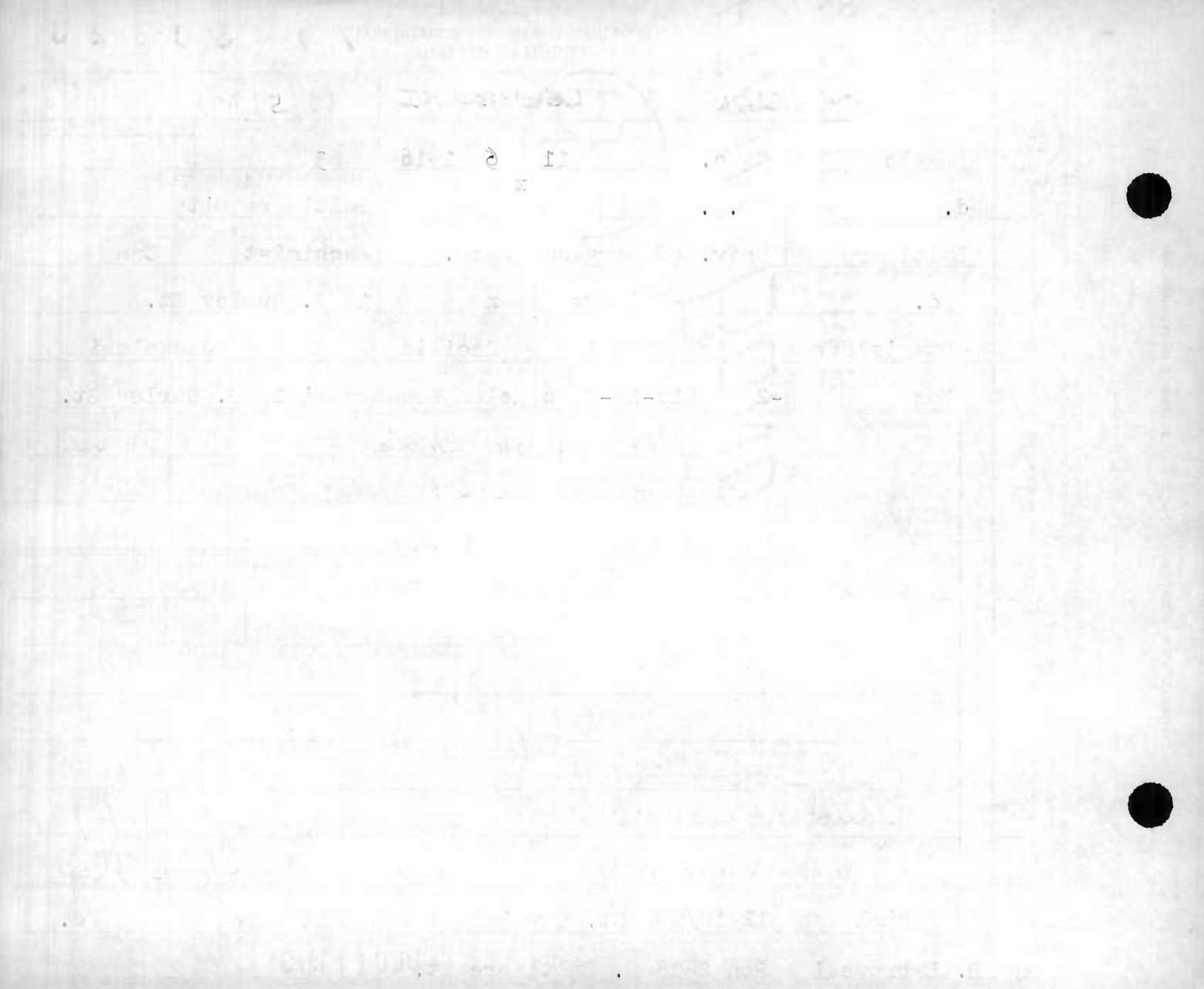
4. The fourth part of the report deals with the political situation. It is a very detailed and thorough account of the current state of politics. The author has done a great deal of research and has gathered a wealth of material. The report is well written and is easy to read. It is a valuable contribution to the study of the country.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

**IMPORTANT:** If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified once the death certificate is completed.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										79 30323							
1. DECEASED NAME (TYPE OR PRINT)			2a. DATE OF DEATH		MONTH		DAY		YEAR		2b. HOUR						
STANISLAUS LEWATOWSKI			12/5/79		12		5		79		11:47 P.M.						
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS.							
Male		Cauc.		12 6 1916		63 YRS.		MONTHS DAYS		HOURS MIN.							
7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7c. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH											
Md.		U.S.A.				Baltimore City MD.											
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY								
Baltimore		Univ. of Maryland Hosp.				Machinist			Can								
13a. STATE										13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS	
Md.												Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		18 S. Curley St.	
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME													
Stanislaus Lewatowski				Cecilia Jaskulski													
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)				16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS											
Yes				WW-2		216-10-0986 Helen Lewatowski 18 S. Curley St.											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIOGENIC Shock</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
410- DUE TO, OR AS A CONSEQUENCE OF (b) <u>ACUTE INFERIOR MYOCARDIAL INFARCTION</u>										2 DAYS							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>PULMONARY EDEMA</u>										2 DAYS							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <u>ATHEROSCLEROTIC PERIPHERAL VASCULAR DISEASE</u>																	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?									
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>									
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED		(ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)											
		HOUR A.M. MONTH DAY YEAR															
21d. INJURY OCCURRED		21e. PLACE OF INJURY		21f. LOCATION													
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		STREET CITY OR TOWN COUNTY STATE													
22a. I certify that (I) (this hospital) attended the deceased from <u>12/4</u> , 19 <u>79</u> , to <u>12/6</u> , 19 <u>79</u> , that (I) (we) last saw the deceased alive on <u>12/6 11:47 pm</u> , 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																	
22b. SIGNATURE				DEGREE				22c. DATE SIGNED									
David S. Prince MD								12/6/79									
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS													
DAVID S. PRINCE MD				UNIVERSITY OF MARYLAND Hosp.													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION		COUNTY		STATE							
Burial		12/10/79		St. Stanislaus Cem		Baltimore				Md.							
24. FUNERAL DIRECTOR NAME				25a. DATE REC'D. BY REGISTRAR				25b. REGISTRAR'S SIGNATURE									
B. Dabrowski & Son 2818 E. Baltimore St.				DEC 11 1979				History/Holbrook									





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

DHMH-16 25M  
(VRA 15, 4) 1/79

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1- FOR STATE REGISTRAR		7 9 3 0 3 2 4		REG. NO.					
1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		2r. DATE OF DEATH MONTH DAY YEAR		2b. HOUR			
George M. Lewis				12 7 79		12:45 PM			
3 SEX		4 RACE		5. DATE OF BIRTH MONTH DAY YEAR		6 AGE (IN YEARS LAST BIRTHDAY)		7 UNDER 1 YEAR	
Male		Negro		4 5 1912		67 YRS.		MONTHS DAYS HOURS MIN.	
7r. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH			
North Carolina		U. S. A.				Baltimore City MD.			
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12r. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
Baltimore		Provident Hospital							
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
Maryland						Baltimore		13e. STREET ADDRESS	
14 FATHER'S NAME FIRST MIDDLE LAST		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17 INFORMANT ADDRESS	
Kailup		Mary Hargrove		No		218-36-3633		Marie Lewis 1512 Retreat Street	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a)		DUE TO, OR AS A CONSEQUENCE OF (b)		DUE TO, OR AS A CONSEQUENCE OF (c)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
496 - Respiratory + Cardiac Arrest		COPD, RLL Pneumonia		Pneumothorax					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 12-1-79, 19 to 12-7-79, that (I) (we) last saw the deceased alive on 12-7-79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE		DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED			
J. K. P. ATHEJA						12-7-79			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS		23a. BURIAL, CREMATION, REMOVAL (SPECIFY)					
J. K. P. ATHEJA		6312 Goldenhook, Columbia		Burial		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY	
				12/13/1979		Mount Calvary Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE	
						Baltimore, Maryland		23e. DATE REC'D. BY REGISTRAR	
						DEC 10 1979		23f. REGISTRAR'S SIGNATURE	
								R. J. McCreedy	
24 FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
W. C. MARCH F. H.		1101 E. NORTH AVE		DEC 10 1979					

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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DHMH-16 25M  
(VRA 15, 4) 1/79

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										7 9 3 0 3 2 5 REG. NO.	
1. FOR STATE REGISTRAR		1a. DECEASED NAME (TYPE OR PRINT) <b>STEPHANIE LEWIS</b>				2a. DATE OF DEATH <b>12/19/79</b>		2b. HOUR <b>10A</b> M			
3 SEX <b>Female</b>		4 RACE <b>White</b>		5 DATE OF BIRTH <b>Aug. 30<sup>th</sup> 1979</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>3</b> YRS <b>19</b> MONTHS <b>19</b> DAYS		7a. IF UNDER 1 YEAR		7b. IF UNDER 24 HRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY</b> MD.					
10 CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>JOHNS HOPKINS HOSPITAL</b>				12a. USUAL OCCUPATION (TYPE OF WORK OR BEST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY <b>NONE</b>			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) <b>Maryland</b>		13b. STATE <b>Baltimore</b>		13c. CITY OR TOWN <b>Essex 21221</b>		13d. INSIDE CITY LIMITS? <b>YES</b> <input type="checkbox"/> <b>NO</b> <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>14 Sidewell Court</b>			
14 FATHER'S NAME <b>Gorman Lewis, Jr.</b>				15. MOTHER'S MAIDEN NAME <b>Paula Brigham</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>None</b>		17 INFORMANT <b>Gorman Lewis, Jr. Father</b>				ADDRESS <b>Same</b>			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I: DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <b>Cardiac arrest due to hyperkalemia</b>											
7454 } DUE TO, OR AS A CONSEQUENCE OF (b) <b>low cardiac output and renal failure</b>											
DUE TO, OR AS A CONSEQUENCE OF (c) <b>Following repair of ventricular septal defect</b>											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION <b>12/18/79</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Ventricular septal defect</b>				20a. AUTOPSY? <b>YES</b> <input type="checkbox"/> <b>NO</b> <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? <b>YES</b> <input type="checkbox"/> <b>NO</b> <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY <b>12/18/79</b> HOUR <b>A.M.</b> MONTH <b>12</b> DAY <b>18</b> YEAR <b>1979</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)							
21d. INJURY OCCURRED <b>WHILE</b> <input type="checkbox"/> <b>NOT WHILE</b> <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) <b>12/18/79</b>		21f. LOCATION <b>12/19/79</b> STREET <b>12/19/79</b> CITY OR TOWN <b>12/19/79</b> COUNTY <b>12/19/79</b> STATE <b>12/19/79</b>							
22a. I certify that (I) (this hospital) attended the deceased from <b>12/18/79</b> 19 <b>12/19/79</b> , to <b>12/19/79</b> 19 <b>12/19/79</b> , that (I) (we) lost <b>show the deceased alive on above, (I) (we) (did) (did not) view the body after death.</b>											
22b. SIGNATURE <b>H.V. Schott, m.d.</b>				DEGREE <b>m.d.</b>				22c. DATE SIGNED			
22a. PHYSICIAN'S NAME (TYPE OR PRINT) <b>H.V. Schott, m.d.</b>				22b. ADDRESS							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>12/21/79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Gardens of Faith</b>				23d. LOCATION <b>Baltimore Co., Md.</b> CITY OR TOWN <b>Baltimore Co., Md.</b> COUNTY <b>Baltimore Co., Md.</b> STATE <b>Baltimore Co., Md.</b>			
24 FUNERAL HOME FOR <b>Radzinski Funeral Home</b> ADDRESS <b>1407 Old Eastern Ave</b>				25a. DATE REC'D. BY REGISTRAR <b>DEC 28 1979</b>				25b. REGISTRAR'S SIGNATURE <b>Barney K. Brady</b>			

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 3 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

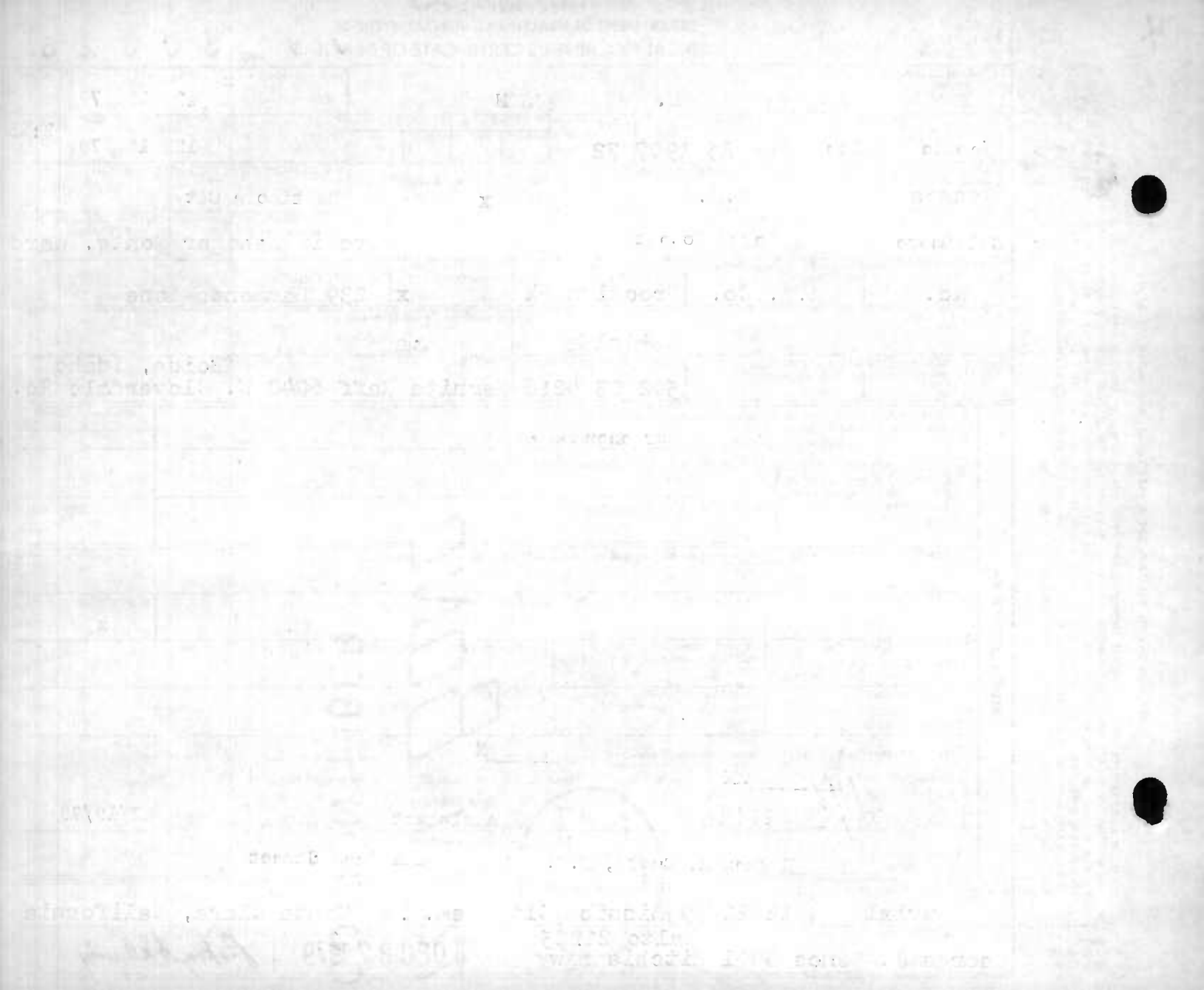
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30M 7/73

FOR  
STATE  
REGISTRAR  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

STATE OF MARYLAND

REG. NO. 30326

1. DECEASED NAME (TYPE OR PRINT) LORIE L. LIEN		2a. DATE KNOWN OF DEATH ESTIMATED 12 18 79		2b. HOUR M
3. SEX female	4. RACE white	5. DATE OF BIRTH MONTH DAY YEAR Nov 25 1907	6. AGE (IN YEARS) (LAST BIRTHDAY) 72 YRS.	7. IF UNDER 1 YR. MONTHS DAYS HOURS MIN
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Kansas	7b. CITIZEN OF WHAT COUNTRY? U.S.A	8. MARRIED WIDOWED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.	
10. CITY OR TOWN OF DEATH Baltimore	11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH PLACE, GIVE STREET ADDRESS) Mercy Hospital	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Credit Manager	12b. KIND OF BUSINESS OR INDUSTRY Montg. Ward	
13a. STATE Md.	13b. COUNTY A.A. Co.	13c. CITY OR TOWN Brooklyn Pk	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS 239 Hammonds Lane
14. FATHER'S NAME FIRST MIDDLE LAST Shields		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Emma		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 502 03 4218		17. INFORMANT ADDRESS Boise, Idaho Bernita Raff 6040 N. Cloverdale Rd.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Lobar pneumonia</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).				
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>				
ACTUAL SIGNATURE <u>H R Guard</u>		TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER		DATE SIGNED 12/19/79
EXAMINER'S NAME (TYPE OR PRINT) Hormez R. Guard, M.D.		ADDRESS 111 Penn Street		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 12/22/79	23c. NAME OF CEMETERY OR CREMATORY Mission City Mem. Pk	23d. LOCATION CITY OR TOWN COUNTY STATE Santa Clara, California	
24. FUNERAL DIRECTOR NAME George J. Gonce		ADDRESS Balto 21225 4001 Ritchie Hgwy		25a. DATE REC'D. BY REGISTRAR DEC 27 1979
				25b. REGISTRAR'S SIGNATURE <u>John H. Brady</u>



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

7 9 3 0 3 2 7  
REG. NO.

FOR  
1 - STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>NATHANIEL, Light Orr</b>			2a. DATE OF DEATH <b>DEC. 28</b> MONTH DAY YEAR <b>79</b> 11:08 AM HOUR	
3 SEX <b>MALE</b>	4 RACE <b>CASIAN</b>	5 DATE OF BIRTH <b>AUG. 18, 1896</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>83</b> YRS.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>POLAND</b>	7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY</b> MD.
10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>SINAI HOSPITAL</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>CLERK</b>	
12b. KIND OF BUSINESS OR INDUSTRY <b>FOOD SERVICE</b>				

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>8102 STREAMWOOD DR. #21208</b>	
13a. STATE <b>MARYLAND</b>	13b. COUNTY <b>BALTO.</b>	13c. CITY OR TOWN <b>BALTIMORE</b>			
14. FATHER'S NAME FIRST <b>MOSES</b> MIDDLE <b>AARON</b> LAST <b>LIGHT</b>		15. MOTHER'S MAIDEN NAME FIRST <b>CELIA</b> MIDDLE <b>LAMB</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>065-28-9149</b>		17 INFORMANT <b>MRS. PAUL LIGHT ORR</b> <b>8102 STREAMWOOD DR. BALTO., MD 21208</b>	

18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardio pulmonary arrest</b> <b>410 -</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>Cardiogenic Shock</b> (c) <b>Recent Myocardial Infarction</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 HR</b> <b>3 days</b> <b>5 days</b>	
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PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

19a. DATE OF OPERATION <b>—</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>—</b>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) <b>—</b>			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) <b>—</b>		21f. LOCATION STREET <b>—</b>		CITY OR TOWN <b>—</b>	
21g. COUNTY <b>—</b>		21h. STATE <b>—</b>					
22a. I certify that (I) (this hospital) attended the deceased from <b>Dec 22</b> , 19 <b>79</b> , to <b>Dec 28</b> , 19 <b>79</b> , that (I) (we) lost saw the deceased alive on <b>28 Dec</b> , 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>Frank W. Braxton, MD</b>				DEGREE <b>MD</b>		22c. DATE SIGNED <b>28 Dec 79</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Frank W. Braxton, MD</b>				22e. ADDRESS <b>Sinai Hospital Baltimore</b>			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>DEC. 30, 1979</b>		23c. NAME OF CEMETERY OR CREMATORY <b>CHIZUKAMUNO</b>		23d. LOCATION CITY OR TOWN <b>BALTIMORE</b>		COUNTY <b>MARYLAND</b>	
24. FUNERAL DIRECTOR (NAME) <b>SOL LEVINSON &amp; BROS., INC.</b> <b>601 REISTERSTOWN RD. BALTO., MD 21215</b>						25a. DATE REC'D. BY REGISTRAR <b>JAN 3 1980</b>		25b. REGISTRAR'S SIGNATURE <b>Robert J. Kelly</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



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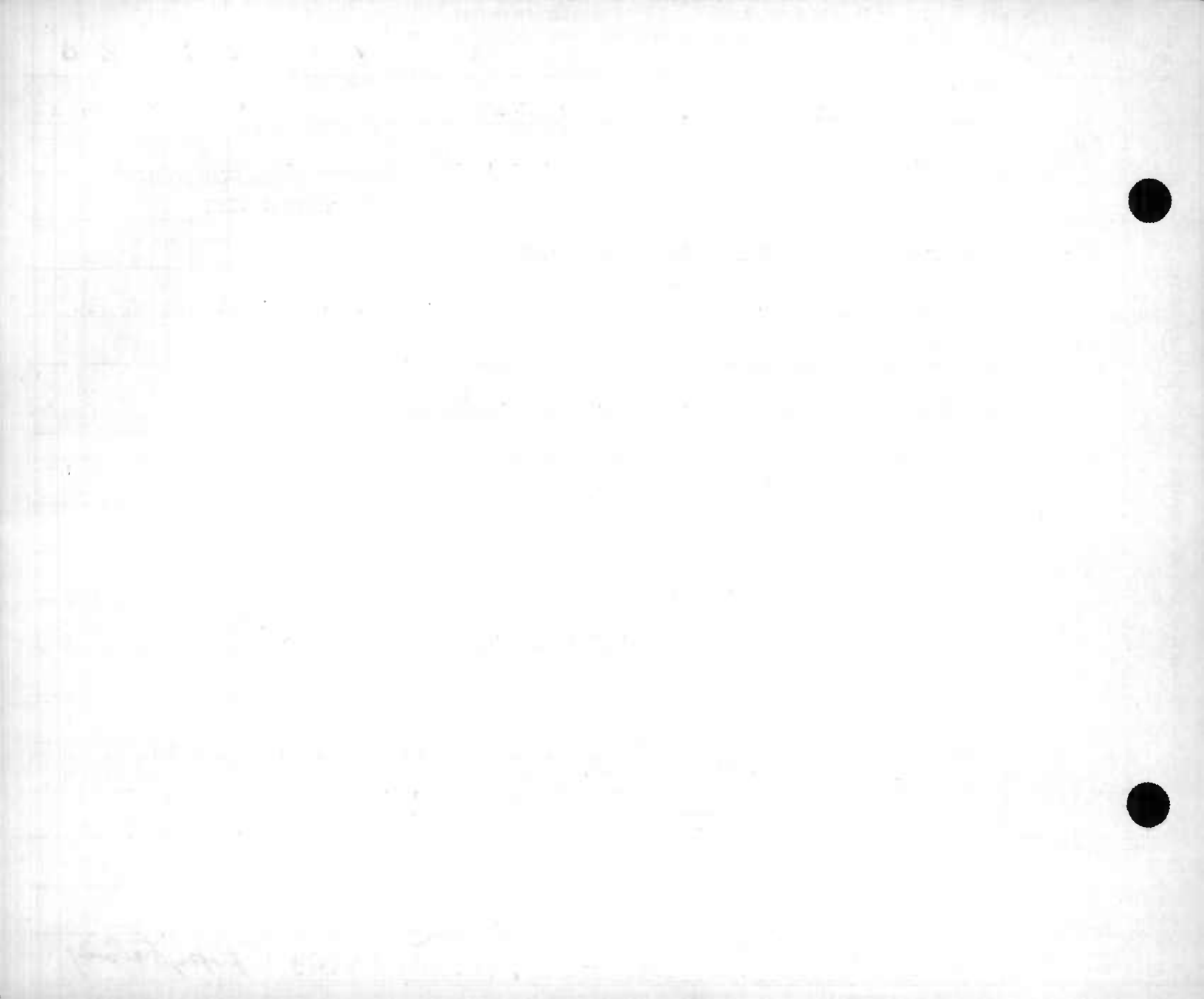
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of one.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 7 9 3 0 3 2 8			
1. FOR STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST EMMA R. Reeder LINDEN						2a. DATE OF DEATH MONTH DAY YEAR 12 10 79			2b. HOUR 1:45 A.M.		
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR Nov. 16, 1888		6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS HOURS MIN 91 YRS			7. IF UNDER 1 YEAR IF UNDER 24 HRS				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.							
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) UNION MEMORIAL HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife			12b. KIND OF BUSINESS OR INDUSTRY Home				
13a. STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN Catonsville		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 319 Woodfield Road 21228					
14. FATHER'S NAME FIRST MIDDLE LAST Alphonse Reeder				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Carrie Muse									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) N/A		17. INFORMANT Mr. Thomas L. Reeder		ADDRESS 2926 Rosemar Dr. Ellicott City, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Failure 4280 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) Congestive Heart Failure DUE TO, OR AS A CONSEQUENCE OF (c) DUE TO, OR AS A CONSEQUENCE OF APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 yrs.													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). Cholecystectomy 11-24-79													
19a. DATE OF OPERATION 11-24-79		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Cholecystitis + Retain				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that (I) (this hospital) attended the deceased from 11-9 19 79 to 12-10 19 79, that (I) (we) lost saw the deceased alive on 11-9 19 79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE Laurie R. Harris				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c. DATE SIGNED 12-10-79					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Laurie R. Harris				22e. ADDRESS 201 E. University PKY 21218									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12/12/79		23c. NAME OF CEMETERY OR CREMATORY Loudon Park		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore City Maryland							
24. FUNERAL DIRECTOR NAME MacNabb Funeral Home				ADDRESS Catonsville, Md.		25a. DATE REC'D. BY REGISTRAR DEC 13 1979		25b. REGISTRAR'S SIGNATURE L. R. Harris					

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(VRA 15, 4) 7/78





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
1. FOR STATE REGISTRAR		7 9 3 0 3 2 9 REG. NO.									
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR	
Jerome		MMW		Lindsey				12-7-79		8:35 P.M.	
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
Male		White		11-6-1900		79 YRS.					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
Balto. Md.		U.S.A.				Baltimore City MD.					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Balto. Md.		Belair Convalesarium						Penna. R.R.		Retired	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS			
Md.				Balto.				1400 E. Baltimore Street			
14. FATHER'S NAME FIRST MIDDLE LAST				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST							
John Lindsey				Mary Murphy							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT		ADDRESS					
Yes		MD		218-10-1231 7		Mr. Robert Ross - 6116 Belair Rd. - 21206					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO, OR AS A CONSEQUENCE OF										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
486- Acute Pneumonia										days	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last											
(b) DUE TO, OR AS A CONSEQUENCE OF											
(c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
Acute Cardiovascular Accident; Advancing aortic aneurysm of the a. larynx.											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)							
		P.M. 19									
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from 11/15/79 to 12/7/79, that (I) (we) lost saw the deceased alive on 11/15/79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.											
22b. SIGNATURE		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED			
Albert B. Bradley		MD						12/10/79			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE					
Burial		12/10-79		Pawwood Cemetery		Balto. Md.					
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
John C. Miller Inc.		-6415 Belair Rd. - 21206		DEC 17 1979		L. J. Bradley					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

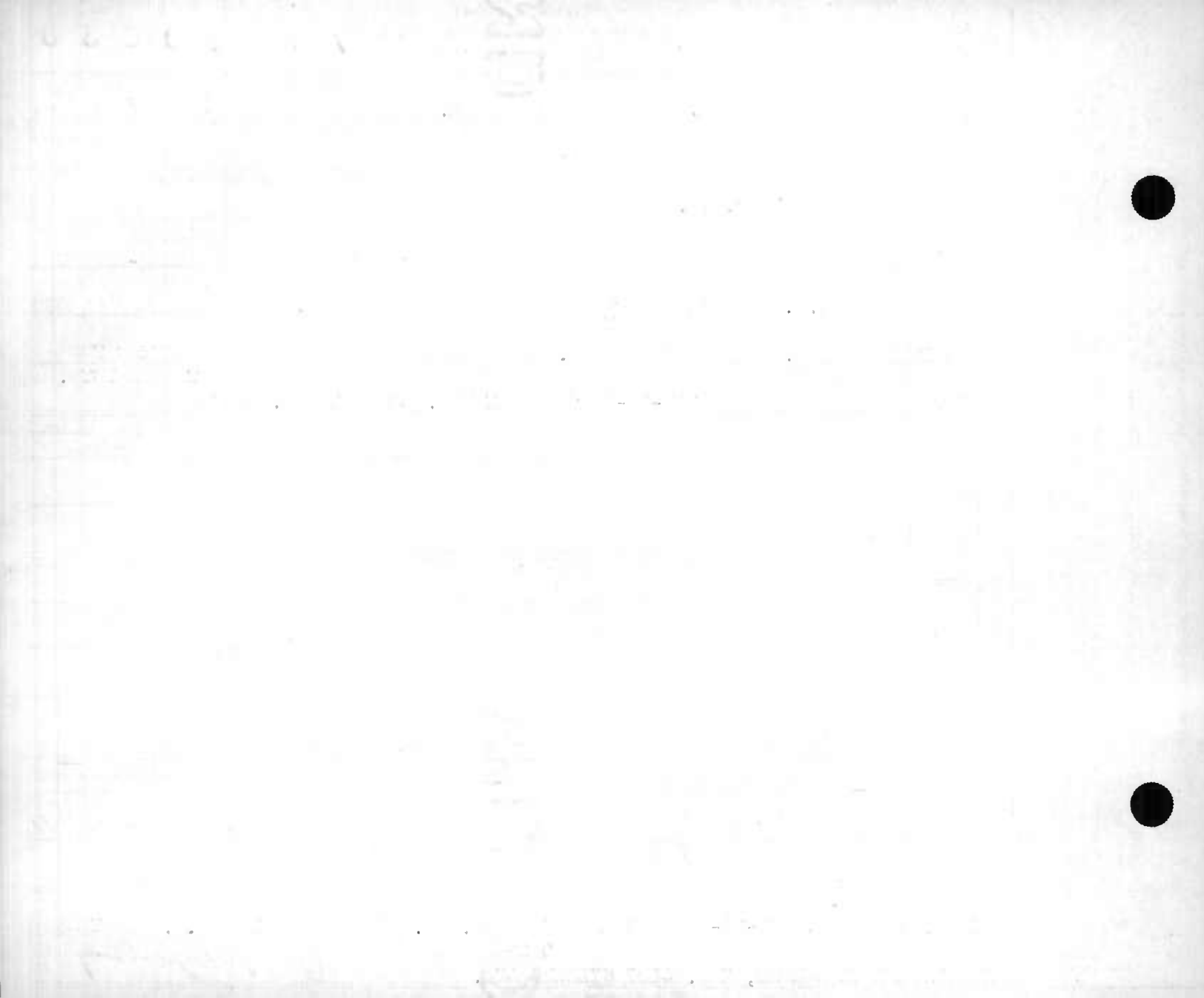
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH															
1. FOR STATE REGISTRAR		7 9 3 0 3 3 0		REG. NO.											
1. DECEASED NAME (TYPE OR PRINT)				2a. DATE OF DEATH		MONTH		DAY		YEAR		2b. HOUR			
HARRY F. LINS SR.				12 20 79		4:37 PM									
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS					
MALE		WHITE		10 06 18		61 YRS.		MONTHS		DAYS		HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH									
MARYLAND		U.S.A.				Baltimore City MD.									
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY			
BALTIMORE				South Baltimore General Hospital				GROCER				SELF-EMPLOYED			
13a. STATE				13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS					
MARYLAND				A.A.		LINTHICUM		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		204 S. LONGCROSS ROAD 21090					
14. FATHER'S NAME FIRST MIDDLE LAST				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST											
WILLIAM F. LINS SR.				NAOMI LIVINGSTON											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)				16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS									
YES				WW II		212-10-6006		DOROTHY A. LINS 204 S. LONGCROSS ROAD							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Terminal Carcinoma of Colon</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>3 years</u>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____															
19a. DATE OF OPERATION <u>Sep. 76</u> <u>Oct. 79</u>				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Carcinoma of Colon</u>				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <u>Sep. 4</u> 19 <u>79</u> , to <u>Oct. 27</u> 19 <u>79</u> , that (I) (we) last saw the deceased alive on <u>Dec. 19</u> 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.															
22b. SIGNATURE <u>Kazuaki Okubo</u>								DEGREE		22c. DATE SIGNED <u>12-20-79</u>					
22e. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Kazuaki Okubo</u>								22d. ADDRESS <u>3001 S. Hanover St. Balt. Md. 21230</u>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE							
BURIAL				12-24-79		GLEN HAVEN MEM. PK.		GLEN BURNIE A.A. MARYLAND							
24. FUNERAL DIRECTOR NAME				ADDRESS				25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
HUBBARD FUNERAL HOME, INC.				4107 WILKENS AVE.				21229		DEC 24 1979		<u>Jeffrey McCreedy</u>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		7 9 3 0 3 3 1				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR
Clarence C. Lipscomb						12/ 27/1979			M
3 SEX		4 RACE		5 DATE OF BIRTH MONTH DAY YEAR		6 AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR MONTHS DAYS	
M		N		08/ 14/ 21		58		YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			
N.C.		USA				Baltimore City MD.			
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Baltimore		St. Agnes Hospital, Balto. MD.							
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE			13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS		
North Carolina			Raleigh				213 East Cabernus Street		
14. FATHER'S NAME FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST						
ROOSEVELT LIPSCOMB			DELILA OWENS						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO		17. INFORMANT		ADDRESS		
Yes			245-16-6319		DAVIS LIPSCOMB		8 N. Ellamont Ave.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> 410- DUE TO, OR AS A CONSEQUENCE OF (b) <u>ASHD</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <u>Previous Myocardial Infarctions</u>									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
						Dec 25 19 59 to Dec 27 19 59			
22. I certify that (I) (this hospital) attended the deceased from above, (I) (we) (did) (did not) view the body after death.									
22a. SIGNATURE <u>E. Myers</u> DEGREE <u>M.D.</u>						22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (TYPE OR PRINT) <u>EVA MYERS M.D.</u>						22d. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE		
Burial			1-2-79		NAT. CEM.		RALEIGH N.C.		
24. FUNERAL DIRECTOR NAME ADDRESS						25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Wm. C. March F/H 1101 E. North Ave.						DEC 31 1979		<u>Trinity McCurdy</u>	

Myocardial Infarction  
A & H D

Obstructive Myocardial Infarction  
✓

Death  
Feb 23 1933  
✓  
E. W. Myers M.D.  
Mr. P.



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1b. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. GIVE PAGE 4 TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM. 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 30332
1. FOR STATE REGISTRAR										
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST (Morris) Maurice L. Lipscomb						2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR 12 10 19 79		2b. HOUR M 5:07 P M		
3. SEX Male	4. RACE Black	5. DATE OF BIRTH MONTH DAY YEAR 1 16 50	6. AGE (IN YEARS) LAST BIRTHDAY 29 YRS.	IF UNDER 1 YR. MONTHS DAYS HOURS MIN.	IF UNDER 24 HRS.	2c. DATE PRONOUNCED DEAD MONTH DAY YEAR 12 10 19 79		2d. HOUR P M		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City, MD.				
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Maryland General Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)										
13a. STATE Maryland		13b. COUNTY		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 1017 Bennett Place		
14. FATHER'S NAME FIRST MIDDLE LAST Herman / Lipscomb, Sr.				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Alvina O. Shivers						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No			16b. SOCIAL SECURITY NO. 219-50-3997		17. INFORMANT ADDRESS Alvina Lipscomb 3322 1/2 Woodland Avenue					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a). <u>Stab wound of left side of chest</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 1:35 PM 12 3 19 79		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) Subject stabbed during argument					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) apartment		21f. LOCATION STREET CITY OR TOWN COUNTY STATE 851 George St., Baltimore Md.					
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input checked="" type="checkbox"/> , Undetermined manner <input type="checkbox"/> .										
ACTUAL SIGNATURE <i>Virginia L. Dolan</i>			TITLE (SPECIFY) Assistant				DATE SIGNED 12/11/79			
EXAMINER'S NAME (TYPE OR PRINT) Virginia L. Dolan, M.D.			ADDRESS 111 Penn Street							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 12/15/79		23c. NAME OF CEMETERY OR CREMATORY Mt. Auburn Cemetery			23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Maryland		
24. FUNERAL DIRECTOR NAME Wm. C. March F/H 1101 East North Avenue					25a. DATE REC'D. BY REGISTRAR DEC 12 1979		25b. REGISTRAR'S SIGNATURE <i>Henry Helms</i>			

1601

MEMORANDUM FOR THE RECORD  
SUBJECT: [Illegible]



[The main body of the document contains several paragraphs of text that are extremely faded and illegible. The text is organized into a memorandum format, likely including a header, a body, and a conclusion. There are also some faint markings that look like initials or a signature in the middle of the page.]

[The bottom section of the document contains additional text, possibly a signature block or a distribution list, which is also illegible due to fading.]

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED IN DIVISION 77 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. 3 0 3 3 3			
1. DECEASED NAME (TYPE OR PRINT) <b>OTHELIA LITTLEJOHNS</b>										2a. DATE KNOWN OF DEATH MONTH <b>12</b> DAY <b>27</b> YEAR <b>79</b>		2b. HOUR <b>1:20</b> AM	
3. SEX <b>female</b>		4. RACE <b>black</b>		5. DATE OF BIRTH MONTH <b>12</b> DAY <b>4</b> YEAR <b>41</b>		6. AGE (IN YEARS) LAST BIRTHDAY <b>38</b> YRS.		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>			7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.				
10. CITY OR TOWN OF DEATH <b>Baltimore</b>				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Bon Secours Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE <b>Maryland</b>				13b. CITY OR TOWN <b>Baltimore</b>		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13d. STREET ADDRESS <b>1820 Riggs Ave.</b>					
14. FATHER'S NAME FIRST <b>OSCAR</b> MIDDLE <b>LITTLEJOHN</b> LAST						15. MOTHER'S MAIDEN NAME FIRST <b>EVELYN</b> MIDDLE <b>JOHNSON</b> LAST							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>No</b>				16b. SOCIAL SECURITY NO. <b>220-36-6202</b>		17. INFORMANT <b>WANDA LITTLEJOHN SAME AS ABOVE</b>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: <b>7999</b> IMMEDIATE CAUSE (a) <b>Undetermined</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>													
ACTUAL SIGNATURE <i>Margarita A. Korell</i>						TITLE (SPECIFY) <b>Assistant</b> M.D. MEDICAL EXAMINER			DATE SIGNED <b>12/27/79</b>				
EXAMINER'S NAME (TYPE OR PRINT) <b>Margarita A. Korell, M.D.</b>						ADDRESS <b>111 Penn Street</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>				23b. DATE <b>12-31-79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>MT. CALVARY CEM.</b>				23d. LOCATION CITY OR TOWN <b>BALTIMORE CO.,</b> COUNTY STATE <b>MD.</b>			
24. FUNERAL DIRECTOR <b>Wm. C. March F/H</b>						1101 E. North Ave.		25a. DATE REC'D. BY REGISTRAR <b>DEC 31 1979</b>		25b. REGISTRAR'S SIGNATURE <i>Henry McCreedy</i>			

TO : DIRECTOR, FBI  
FROM : SAC, NEW YORK  
SUBJECT: [Illegible]

Re New York letter to Bureau dated 1/15/64.

Enclosed for the Bureau are two copies of a letterhead memorandum (LHM) dated and captioned as above.

The LHM is being furnished to the New York Office for its information.

Very truly yours,  
[Illegible Signature]

Very truly yours,  
[Illegible Signature]

Special Agent in Charge

Enclosure

RECEIVED  
JAN 21 1964  
FBI NEW YORK

cc: New York Office

cc: [Illegible]

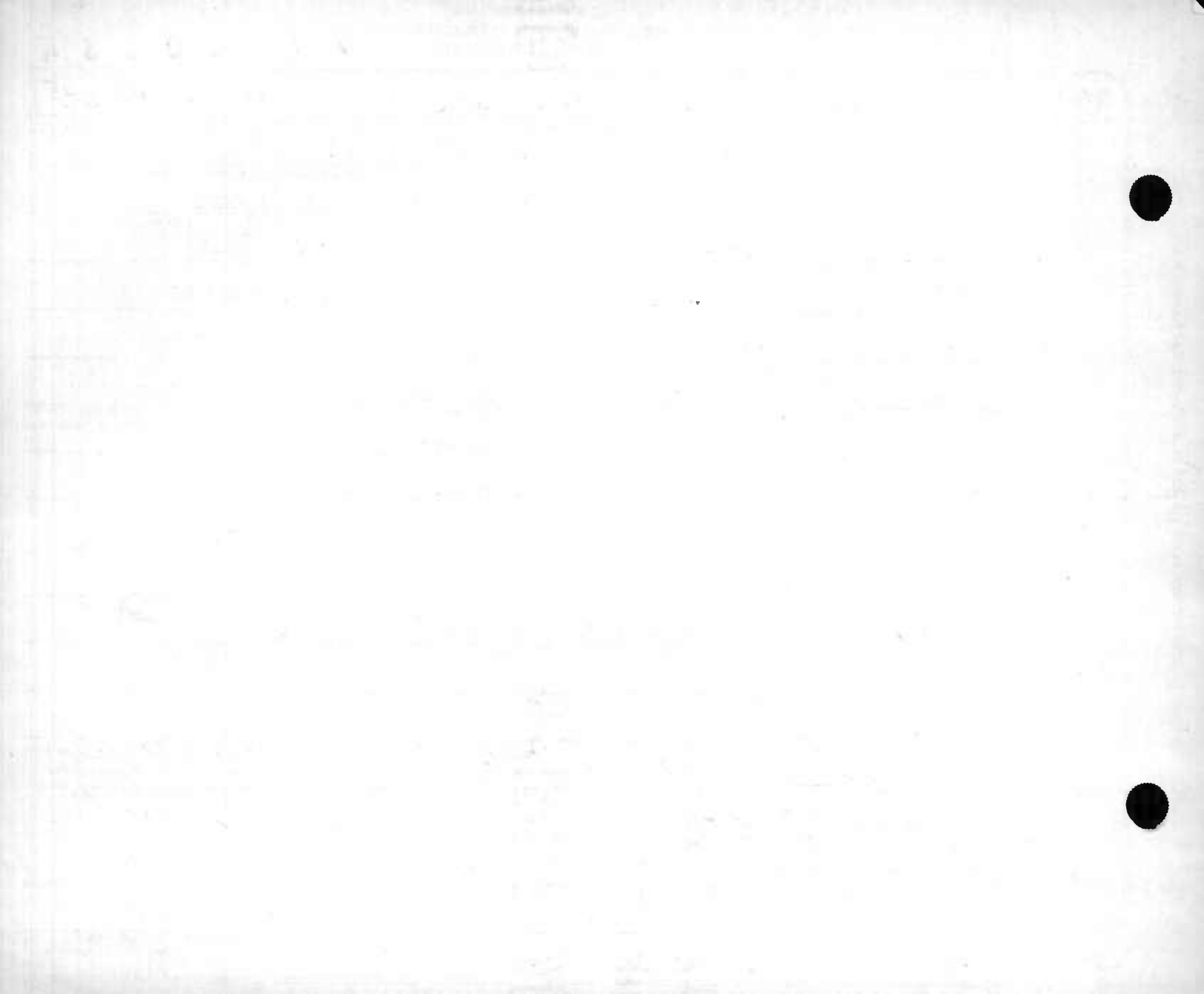
ADMINISTRATIVE PAGE TWO

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		7 9 3 0 3 3 4 REG. NO.							
1. DECEASED NAME (TYPE OR PRINT) MILLARD E. LITSINGER				2a. DATE OF DEATH 12-18-79				2b. HOUR 6 <sup>05</sup> AM	
3. SEX Male		4. RACE White		5. DATE OF BIRTH Sept. 28, 1885		6. AGE (IN YEARS LAST BIRTHDAY) 94 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.			
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) UNION MEMORIAL HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Shipping Clerk		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE Maryland		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 2802 Goodwood Rd			
14. FATHER'S NAME FIRST MIDDLE LAST ? Litsinger				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Elmira (Unk)					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 212-01-0414A		17. INFORMANT Mrs Mildred E Smith				ADDRESS Same	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac failure</u> 7854 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <u>Renal failure</u> (c) <u>Gangrene of Rt leg and foot</u>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): <u>me</u>									
19a. DATE OF OPERATION 12/16/79		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Gangrene Rt leg & foot				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>12/16/79</u> to <u>12/18/79</u> , that (I) (we) lost saw the deceased <u>live on 12/18/79</u> , and that in <u>my</u> (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>Onkar Nath Singh</u>				DEGREE MD.				22c. DATE SIGNED 12/18/79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ONKAR NATH SINGH				22e. ADDRESS Union Memorial Hosp. Baltimore, Md					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12/20/79		23c. NAME OF CEMETERY OR CREMATORY Loudon Park		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Maryland			
24. FUNERAL DIRECTOR NAME Leonard J Ruck Inc. Baltimore, Maryland				25a. DATE REC'D. BY REGISTRAR DEC 18 1979		25b. REGISTRAR'S SIGNATURE <u>History McCreedy</u>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
1. FOR STATE REGISTRAR		7 9		3 0 3 3 5		REG. NO.					
1 DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a DATE OF DEATH MONTH DAY YEAR			2b HOUR		
Irene Livingston						12 27 79			11 pm		
3 SEX		4 RACE		5 DATE OF BIRTH MONTH DAY YEAR		6 AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS	
Female		Black		12 25 1913		66 YRS.		MONTHS DAYS		HOURS MIN	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH					
S. C.		USA				Baltimore, Mar City MD.					
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b KIND OF BUSINESS OR INDUSTRY			
Balto.		4908 Carmine Ave.				House wife					
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)						13a STREET ADDRESS					
13a STATE		13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS?					
Md				Balto.		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		4908 Carmine Ave.			
14 FATHER'S NAME FIRST MIDDLE LAST						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST					
? ?						Mild Martha Livingston Nelson					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)				16b SOCIAL SECURITY NO.		17 INFORMANT ADDRESS					
No				246 03 4166D		Mildred Livingston 4908 Carmine Ave.					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I: DEATH WAS CAUSED BY.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (a) Congestive heart failure										several hours	
DUE TO, OR AS A CONSEQUENCE OF (b) Hypertensive cardiovascular disease										several years	
DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (d)											
Diabetes											
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY?		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a ACCIDENT WAS UNDERLYING OR CONTRIBUTORY CAUSE OF DEATH (IF EITHER, LIST MEDICAL EXAMINER)			21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR			21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
			P.M. 19								
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> EN ROUTE TO WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f LOCATION STREET CITY OR TOWN COUNTY STATE					
22a I certify that (I) (this hospital) attended the deceased from 12/27 19 79 to 12/27 19 79, that (I) (we) last saw the deceased alive on 12/27 19 79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b SIGNATURE						DEGREE		22c DATE SIGNED			
D. W. STEWART, M.D.						ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		12/31/79			
22d PHYSICIAN'S NAME (TYPE OR PRINT)						22e ADDRESS					
D. W. STEWART, M.D.						2300 Garrison Blvd.					
23a BURIAL, CREMATION, REMOVAL (SPECIFY)			23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION CITY OR TOWN COUNTY STATE				
Burial			12-31-79		Western Star Cem.		Baltimore, Maryland				
24 FUNERAL DIRECTOR NAME ADDRESS						25a DATE REC'D. BY REGISTRAR		25b REGISTRAR'S SIGNATURE			
Isaiah L. Brown & Son PA 1913 W. Balto. St.						JAN 3 1980		Isaiah L. Brown			



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed in the office of the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										7 9 3 0 3 3 6 REG. NO.	
1. FOR STATE REGISTRAR					2a. DATE OF DEATH		MONTH DAY YEAR		2b. HOUR		
1. DECEASED NAME (TYPE OR PRINT) <i>Alford B. Boy</i>					2a. DATE OF DEATH		MONTH DAY YEAR		2b. HOUR		
3 SEX		4 RACE		5 DATE OF BIRTH		6 AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS	
Male		Black		11/10/79		YRS.		MONTHS DAYS		HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH					
BALTIMORE		BALTIMORE		ST. AGNES HOSPITAL		BALTIMORE CITY MD.					
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY					
BALTIMORE		ST. AGNES HOSPITAL		none							
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS			
Maryland		A.A.		Annapolis		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		72 Southgate Ave.			
14 FATHER'S NAME					15. MOTHER'S MAIDEN NAME						
FIRST MIDDLE LAST					FIRST MIDDLE LAST						
unknown					Gloria Ann Lloyd						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)					16b. SOCIAL SECURITY NO.		17 INFORMANT ADDRESS				
					none		Gloria Ann Lloyd, 72 Southgate Ave.				
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Acute Renal Failure</i>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
7705 } DUE TO, OR AS A CONSEQUENCE OF (b) <i>Atelectasis of lungs</i>										5 days	
DUE TO, OR AS A CONSEQUENCE OF (c) <i>Prematurity (38 weeks)</i>										1 mo.	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
							YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
			HOUR A.M. MONTH DAY YEAR								
21d. INJURY OCCURRED			21e. PLACE OF INJURY			21f. LOCATION					
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			STREET CITY OR TOWN COUNTY STATE					
22. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.											
27b. SIGNATURE						DEGREE		27c. DATE SIGNED			
<i>Anthony A. APC</i>						MD		12/6/79			
27d. PHYSICIAN'S NAME (TYPE OR PRINT)						27e. ADDRESS					
Anthony A. APC						900 CATON AVE. BALTIMORE, MD. 21220					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION			
Burial			12/15/79		New Cathedral			Baltimore Maryland			
24 FUNERAL DIRECTOR 1630 Edmondson Ave., Balto. Md						25a. DATE REC'D. BY REGISTRAR					
Witzke Funeral Home						DEC 18 1979					

DAVID H. SHAW

ST. JOSEPH HOSPITAL

Baltimore

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

5  
1

FOR  
STATE  
REGISTRAR

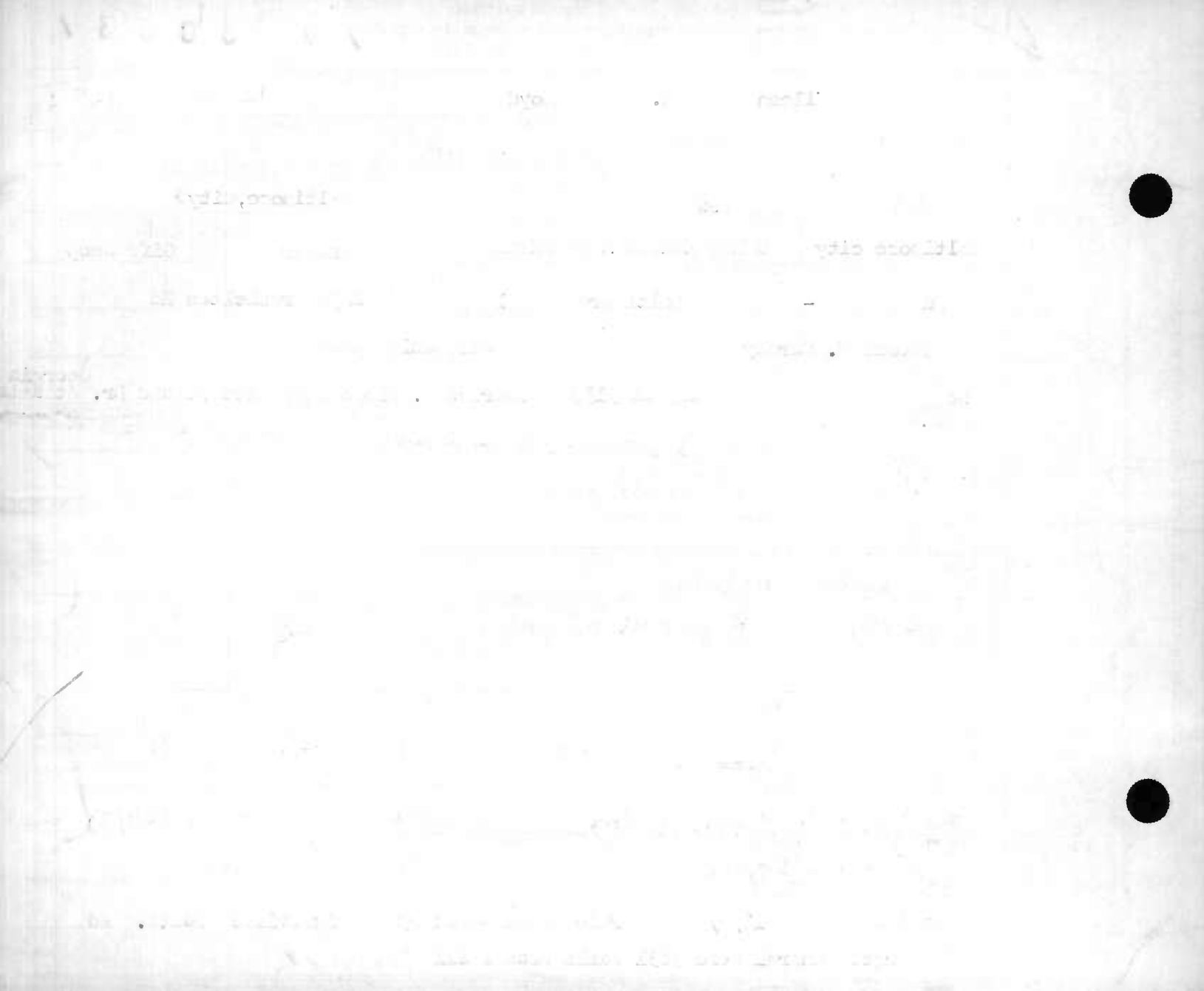
STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

7 9

3 0 3 3 7

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>Eileen C. Lloyd</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>12 01 79</b>			2b. HOUR <b>12<sup>10</sup> AM</b>			
3 SEX <b>female</b>		4 RACE <b>white</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>01 25 1910</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>69</b> YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>ND</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore, City</b> MD.			
10 CITY OR TOWN OF DEATH <b>Baltimore city</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>UNION MEMORIAL HOSPITAL</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Manager</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Gift Shop</b>	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Md</b>		13b. COUNTY <b>-</b>		13c. CITY OR TOWN <b>Baltimore</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>2434 Brambelton Rd</b>	
14 FATHER'S NAME FIRST MIDDLE LAST <b>Thomas B. Carney</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Stephanie Bunn</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>no</b>		16b. SOCIAL SECURITY NO. <b>243 68 3153</b>		17 INFORMANT ADDRESS <b>Charles E. Lloyd 4495 Cove Island Dr. Atlanta Georgia</b>					
11 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Cardiopulmonary arrest</b> <b>4538</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Acute MI</b> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>Diabetes mellitus</b>									
19a. DATE OF OPERATION <b>11/29/79</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Ⓡ femoral thrombosis</b>				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>11/30</b> 19 <b>79</b> , to <b>12/1</b> 19 <b>79</b> , that (I) (we) last saw the deceased alive on <b>11/30 12/1</b> 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>John H. Epple</b>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED <b>12/1/79</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>John H. Epple</b>				22e. ADDRESS <b>UNION Memorial Hospital</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>12/1/79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Druid Ridge Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Pikesville Balto. Md</b>			
24 FUNERAL DIRECTOR NAME <b>Burgee Funeral Home</b>				ADDRESS <b>3631 Falls Road 21211</b>		25a. DATE REC'D. BY REGISTRAR <b>12/06/79</b>		25b. REGISTRAR'S SIGNATURE	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Please retain the certificate for 24 hours after death. Please return to the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR  
1 - STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

79

REG. NO.

30338

1 DECEASED NAME (TYPE OR PRINT) George William LOBER			2a. DATE OF DEATH MONTH DAY YEAR DECEMBER 21, 1979			2b. HOUR 7:15 M			
3 SEX Male		4 RACE White		5 DATE OF BIRTH MONTH DAY YEAR Nov. 23, 1894		6 AGE (IN YEARS LAST BIRTHDAY) 85 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.			
10 CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 310 Rossiter Avenue				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Trust Clerk		12b. KIND OF BUSINESS OR INDUSTRY Md. Nat. Bnk	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a. STATE Maryland		13b. COUNTY		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 310 Rossiter Avenue	
14 FATHER'S NAME FIRST MIDDLE LAST George Lober					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Annie Mary Schwinger				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW I		17 INFORMANT Mrs. Elsie W. Lober			ADDRESS Same	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic obstructive lung disease DUE TO, OR AS A CONSEQUENCE OF (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (b) Arteriosclerosis + Coroner's Bladder									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK HOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) 1963			21f. LOCATION STREET CITY OR TOWN COUNTY STATE Dec 21 79			
22a. I certify that (I) (this hospital) attended the deceased from [Signature] 19 79 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (we) (we) saw the body after death.									
22b. SIGNATURE [Signature]			22c. DATE SIGNED 12/21/79			22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. William G. Helfrich, M.D.			
22e. ADDRESS 5006 Roland Ave. Balto., Md. 21212			22f. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 12/24/79		23c. NAME OF CEMETERY OR CREMATORY Loudon Park		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Md.		
24 FUNERAL DIRECTOR NAME Henry W. Jenkins & Sons Co. 4905 York Road Balto., Md. 21212						25a. DATE REC'D. BY REGISTRAR DEC 24 1979		25b. REGISTRAR'S SIGNATURE [Signature]	

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1943 Dec 21 1943

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Charles Frederick King

Charles Frederick King

1943 Dec 21 1943

1943 Dec 21 1943

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, and completed by the funeral director, it should be detached for use as the burial-transit permit. Then please remove and retain pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or reburial.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										7 9 3 0 3 3 9			
1. FOR STATE REGISTRAR		REG. NO.											
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR
SARAH		LOCKLEAR						DECEMBER 14, 1979					7:50A
3 SEX		4 RACE		5 DATE OF BIRTH		6 AGE (IN YEARS LAST BIRTHDAY)		7 IF UNDER 1 YEAR		8 IF UNDER 24 HRS			
FEMALE		WHITE		2 / 5 / 1915		64		MONTHS		DAYS		HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH							
ROBESON N.C.		U.S.A.		WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		BALTIMORE CITY							
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION		12a. USUAL OCCUPATION		12b. KIND OF BUSINESS OR INDUSTRY							
BALTIMORE		THE JOHNS HOPKINS HOSPITAL		HOUSEWIFE		INDUSTRIAL							
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS					
MARYLAND				BALTIMORE		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		1931 BALTIMORE STREET 2231					
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME											
JIM		CORA											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO		17 INFORMANT		ADDRESS							
NO				LUTHER LOCKLEAR JR.		#4 ROWAN TRAILER PARK							
18 CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c.)		18b. SOCIAL SECURITY NO		17 INFORMANT		ADDRESS							
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)													
410- ventricular arrhythmia												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DUE TO, OR AS A CONSEQUENCE OF (b)												45 minutes	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last												6 days	
DUE TO, OR AS A CONSEQUENCE OF (c)												20 years	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)													
diabetes mellitus, high blood pressure													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?							
				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED									
		HOUR A.M. MONTH DAY YEAR		(ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)									
21d. INJURY OCCURRED		21e. PLACE OF INJURY		21f. LOCATION									
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>		(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		STREET		CITY OR TOWN		COUNTY		STATE			
22a. I certify that (I) (this hospital) attended the deceased from 12/8 1979, to 12/14 1979, that (I) (we) lost													
saw the deceased alive on 12/13 1979, and that in my (our) opinion death occurred on the date and hour and from the causes stated													
22b. SIGNATURE		DEGREE		22c. DATE SIGNED									
Joseph Wachspress MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		12/14/79									
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS											
JOSEPH WACHSPRESS		601 N. Broadway, Balto. Rod 21205											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION		COUNTY		STATE			
BURIAL		12/ 18 / 79		BURNT SWAMP CEMETERY		ROBESON		NORTH CAROLINA					
24. FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE									
THE DIPPEL BROTHERS INC. 7110 Balair Rd. 21206		DEC 18 1979		Ricky Bell									



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

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DHMH - 16 50M 1/76  
(VR A 15 (4))

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

7 9 3 0 3 4 0

REG. NO.

1. FOR  
STATE  
REGISTRAR

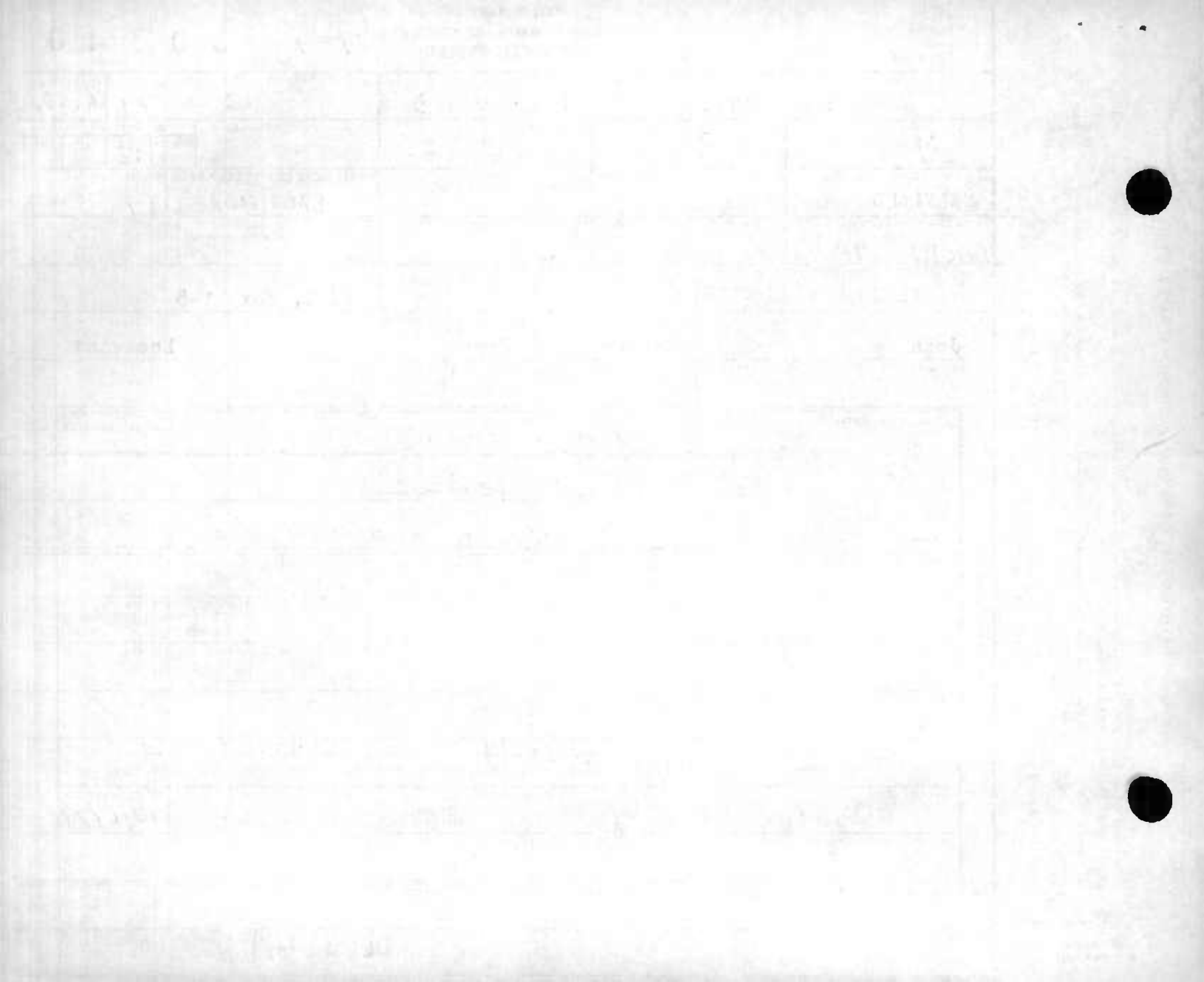
1. DECEASED NAME (TYPE OR PRINT)		FIRST BB JOYCE	MIDDLE LOCKWOOD	LAST LOCKWOOD	2a. DATE OF DEATH		MONTH 12	DAY 6	YEAR 79	2b. HOUR 6.53pM	
3 SEX M		4 RACE B		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR MONTHS 13		IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.					
10 CITY OR TOWN OF DEATH BALTO MD		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) BALTIMORE CITY/HOSP				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE MARYLAND		13b. COUNTY WORCESTER		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS RT 1, Box 140			
14. FATHER'S NAME FIRST John				MIDDLE Hatton		15. MOTHER'S MAIDEN NAME FIRST Joyce		MIDDLE Lockwood		LAST	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)				16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>cardiac arrest</u> 7689 DUE TO, OR AS A CONSEQUENCE OF (b) <u>renal failure</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) <u>Prematurity and asphyxia</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
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PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>12/2/79</u> 19 to <u>12/6/79</u> 19, that (I) (we) lost saw the deceased alive on <u>12/6/79</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>Soy Wong Kouserhoff</u>				DEGREE		22c. DATE SIGNED 12/6/79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) WONG				22e. ADDRESS BCH			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE	

24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR DEC 31 1979		25b. REGISTRAR'S SIGNATURE <u>Robert M. Brady</u>	
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed in the office of the Registrar of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		7 9 3 0 3 4 1 REG. NO.							
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST PEGGY T. LOGAN.						2a. DATE OF DEATH MONTH DAY YEAR Dec 11. 1979		2b. HOUR 12:08 PM	
3. SEX F.		4. RACE NEGRO		5. DATE OF BIRTH MONTH DAY YEAR 09. 30. 28		6. AGE (IN YEARS LAST BIRTHDAY) 51 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? US of A		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.			
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) PROVIDENT HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) UNEMPLOYED		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE MARYLAND		13b. COUNTY		13c. CITY OR TOWN BALTIMORE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 1812 ASHBURTON STREET	
14. FATHER'S NAME FIRST MIDDLE LAST UNKNOWN				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ETHEL FORREST					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 216 20 8168		17. INFORMANT ADDRESS MRS. PONI J. JOHNSON 5223 DENMORE AVENUE					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIO RESPIRATORY ARREST</u> <u>2030</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <u>Multiple Myeloma with Bence-Jones Protein.</u> (c) <u>Sacred death with hypoxia.</u>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)									
19a. DATE OF OPERATION None.		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>12-03-79</u> 19 <u>79</u> to <u>12-11-79</u> 19 <u>79</u> , that (I) (we) last saw the deceased alive on <u>12-11-79</u> 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>Richard</u>				DEGREE MD. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c. DATE SIGNED 12-11-79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Stk. ANAND.				22e. ADDRESS 26W Liberty Hts. Apt. 21215					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 12/14/79		23c. NAME OF CEMETERY OR CREMATORY WESTVIEW MEMORIAL PK.		23d. LOCATION CITY OR TOWN COUNTY STATE CATONSVILLE (BALTO.) MD.			
24. FUNERAL DIRECTOR NAME LEWIS T. GWYNN				ADDRESS 4517 PARK HEIGHTS AVENUE		25a. DATE REC'D. BY REGISTRAR DEC 13 1979		25b. REGISTRAR'S SIGNATURE <u>John H. Brady</u>	

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1200

YTO BARRACKS

CHRYSTIAN

1925 ASSURANCE STREET

PORT

215 SC 1188

WILLIAM L. JOHNSON 3223

DEPT. OF JUSTICE

WASHINGTON, D.C.

12/11/77

12/11/77

12/11/77

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH7 9 3 0 3 4 2  
REG. NO.1 - FOR  
STATE  
REGISTRAR

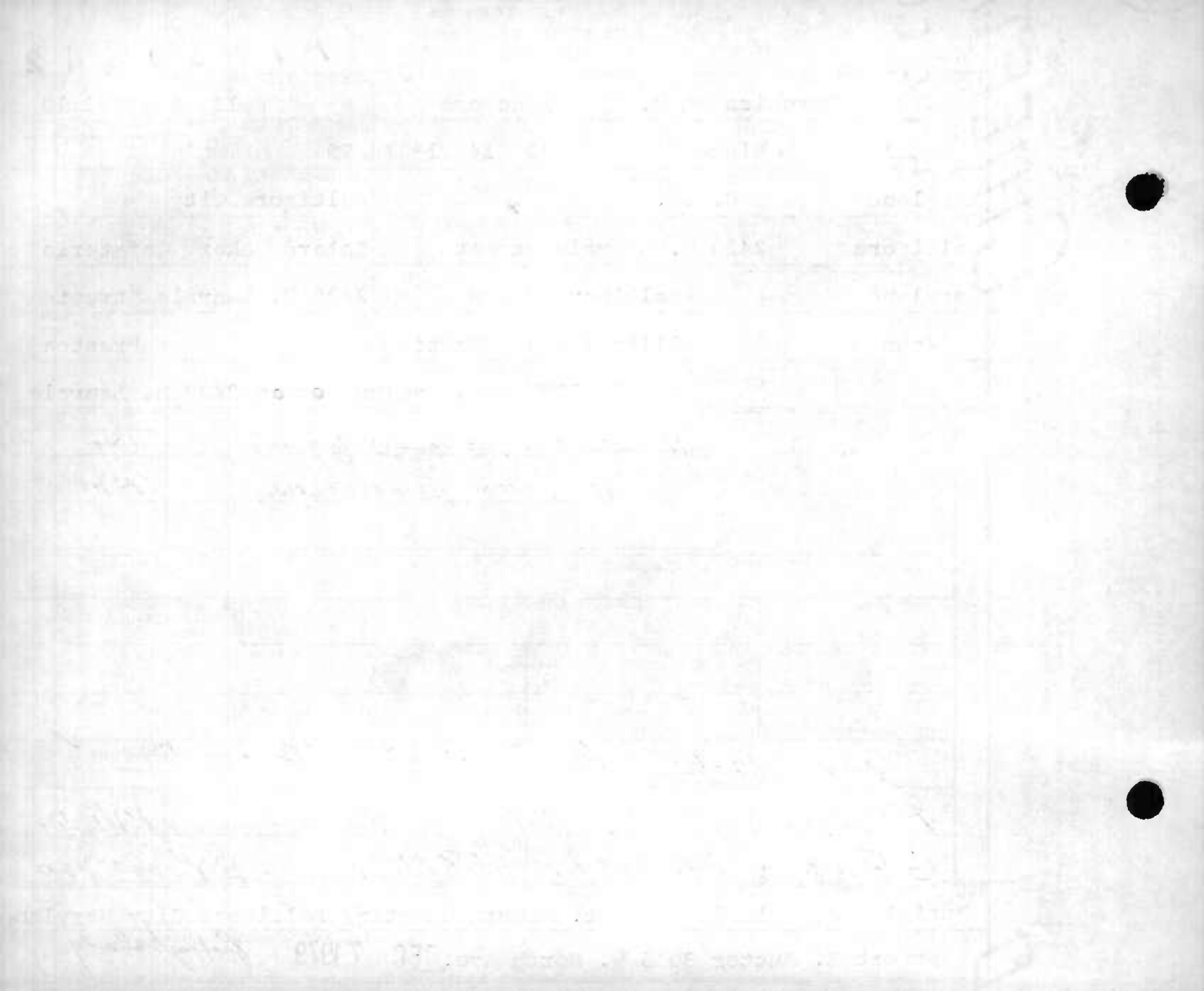
1 DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST	2a DATE OF DEATH		MONTH	DAY	YEAR	2b HOUR	
Veronica M. Lonesome					12 6 1979					2:10 M	
3 SEX		4 RACE		5 DATE OF BIRTH		6 AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS	
Female		Black		02 14 1901		78		MONTHS DAYS		HOURS MIN.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH					
Maryland		U.S.A.				Baltimore City MD.					
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b KIND OF BUSINESS OR INDUSTRY			
Baltimore		2420 W. Lanvale Street				Salard Maker		Cafateria			
13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS?		13e STREET ADDRESS			
Maryland				Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		2420 W. Lanvale Street			
14 FATHER'S NAME				15 MOTHER'S MAIDEN NAME							
John Williams				Hattie Preston							
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b SOCIAL SECURITY NO.		17 INFORMANT		ADDRESS					
NO		061-12-1775		Mrs. Evelyn Gordon		2420 W. Lanvale					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hypertension &amp; Coronary Artery Disease</u> 4029 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Acute Cerebral Hemorrhage</u> (c) <u></u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 Yr. 74 hr.	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):											
19a DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
						YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from 12-8-78 to 12-6-79, that (I) (we) lost saw the deceased alive on 12-6-79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b SIGNATURE		DEGREE				22c. DATE SIGNED					
G. Franklin Phillips M.D.		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				12/7/79					
22d PHYSICIAN'S NAME (TYPE OR PRINT)		22e ADDRESS									
G. Franklin Phillips MD		538 McMedan St. Baltimore, MD 21201									
23a BURIAL, CREMATION, REMOVAL (SPECIFY)		23b DATE		23c. NAME OF CEMETERY OR CREMATORY		23d LOCATION CITY OR TOWN COUNTY STATE					
Burial		12-10-1979		Mt. Auburn Cemetery		Baltimore City Maryland					
24 FUNERAL DIRECTOR NAME				25a DATE REC'D. BY REGISTRAR		25b REGISTRAR'S SIGNATURE					
Herbert E. Nutter 3035 W. North Ave.				FEC 7 1979		[Signature]					

MEDICAL CERTIFICATION

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 3 may be retained by the hospital or attending physician.





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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										
1. FOR STATE REGISTRAR		7 9 3 0 3 4 3 REG. NO.								
1. DECEASED NAME (TYPE OR PRINT)		FIRST DESSIE		MIDDLE		LAST LOOKINGBILL		2a. DATE OF DEATH MONTH DAY YEAR 12 27 79		2b. HOUR 545 P.M.
3. SEX F		4. RACE W		5. DATE OF BIRTH MONTH DAY YEAR 5 21 78		6. AGE (IN YEARS LAST BIRTHDAY) 1		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) PA. MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.				
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) UNIVERSITY MARYLAND HOSP.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) —		12b. KIND OF BUSINESS OR INDUSTRY —		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD		13b. COUNTY CARROLL		13c. CITY OR TOWN TANeyTOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 45 E. Baltimore St.		
14. FATHER'S NAME FIRST MIDDLE LAST CHARLES LOOKINGBILL		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST CAROLYN ANDREW								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		(IF YES, GIVE WAR OR DATES)		16b. SOCIAL SECURITY NO. —		17. INFORMANT ADDRESS Chas. Lookingbill - 45 E. BALTO. ST. MD. 21787				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) SEPTIC SHOCK 0411 DUE TO, OR AS A CONSEQUENCE OF (b) STAPHYLOCOCCAL MEDIASTINITIS DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c) CONGENITAL HEART DISEASE										
19a. DATE OF OPERATION 10/29/79		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED VENTRICULAR SEPTAL DEFECT				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (his hospital) attended the deceased from 10/29/79, 19 79, to 12-27, 19 79, that (I) (we) last saw the deceased alive on 12/27, 19 79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE Anthony L. Moulton		DEGREE M.D.		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 12/27/79				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ANTHONY L. MOULTON		22e. ADDRESS 22 S. Greene St., Baltimore, Md.								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE Dec 29, 1979		23c. NAME OF CEMETERY OR CREMATORY OAK Hill Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE LEGORE FRED. MD.				
24. FUNERAL DIRECTOR NAME SKILES FUNERAL Home - 136 E. BALTO. ST. TANeyTOWN		ADDRESS MD. 21787		25a. DATE REC'D. BY REGISTRAR JAN 1 1980		25b. REGISTRAR'S SIGNATURE				



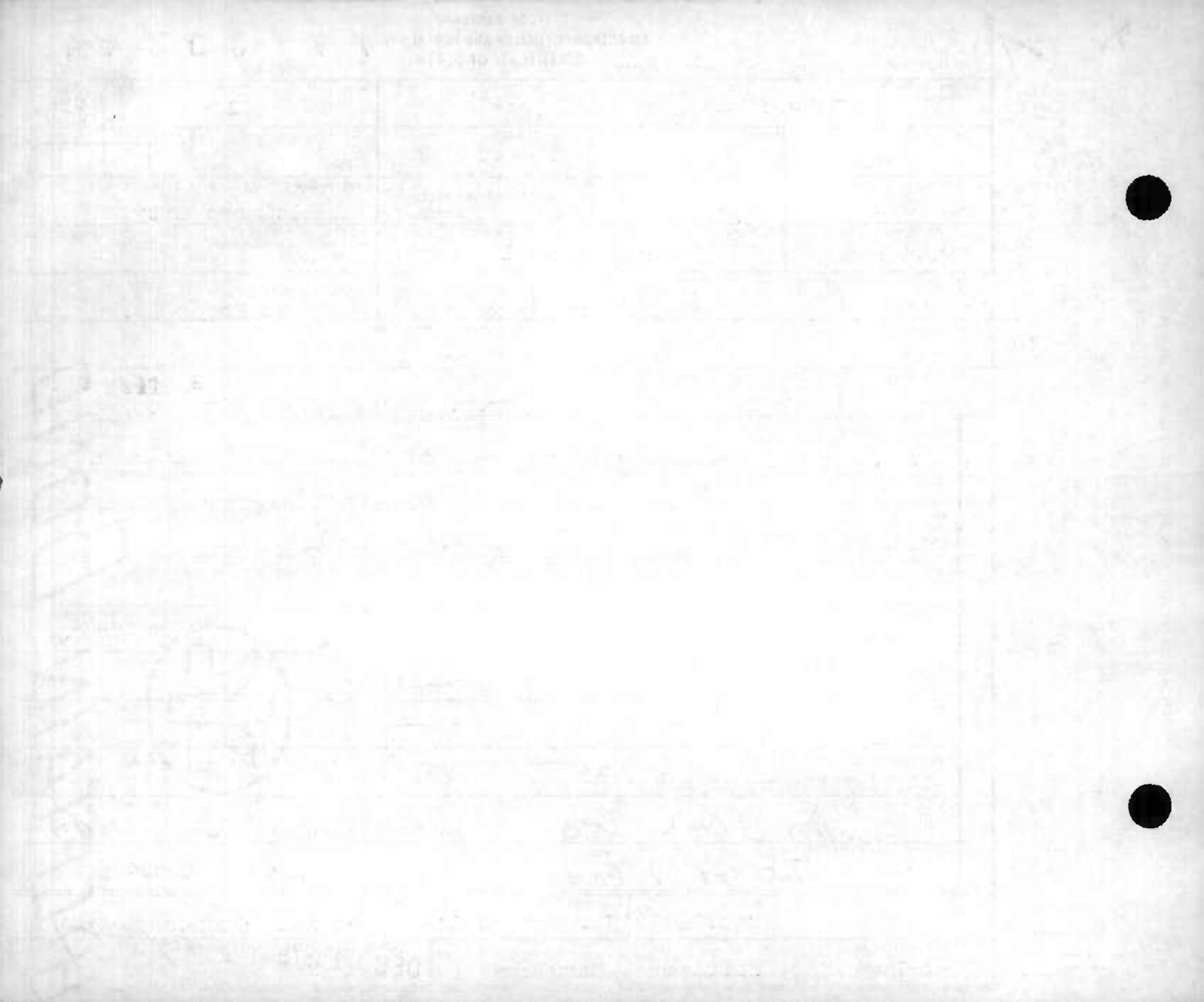


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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										
1- FOR STATE REGISTRAR <b>James Walter Loop</b>										
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>JAMES Walter LOOP</b>					2a. DATE OF DEATH MONTH DAY YEAR <b>12 8 79</b>					
3. SEX <b>MALE</b>		4. RACE <b>CAUC.</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>1/ 11/ 11</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>68</b> YRS		7b. HOUR <b>8:40 P M</b>		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>New York</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.				
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Mercy Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Clerk</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Soc. Sec. Ad</b>		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Maryland</b>					13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Baltimore</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Walter M Loop</b>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Mary Kenna</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b>		16b. SOCIAL SECURITY NO. <b>WW II 105-05-4902</b>		17. INFORMANT ADDRESS <b>Mr. T. Sherman Loop Liverpool, N.Y. 623 First St.</b>						
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiopulmonary Arrest</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Probable Pericardial Tamponade</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Pericardial Metastatic Cancer</b> 1641 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>12/8/79</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from <b>11/17</b> , 19 <b>79</b> , to <b>12/8</b> , 19 <b>79</b> , that (I) (we) last saw the deceased alive on <b>12/8</b> , 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <b>Jeffrey D. Gaber, MD</b> DEGREE					ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			22c. DATE SIGNED <b>12/8/79</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>JEFFREY D. GABER</b>					22e. ADDRESS <b>Mercy Hospital 21202</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>Dec. 12, 79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>St. Mary's Cem.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Dewitt, Onondaga</b>				
24. FUNERAL DIRECTOR NAME <b>Duda-Ruck, Inc., Baltimore, Maryland</b>					25a. DATE REC'D. BY REGISTRAR <b>DEC 11 1979</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>			



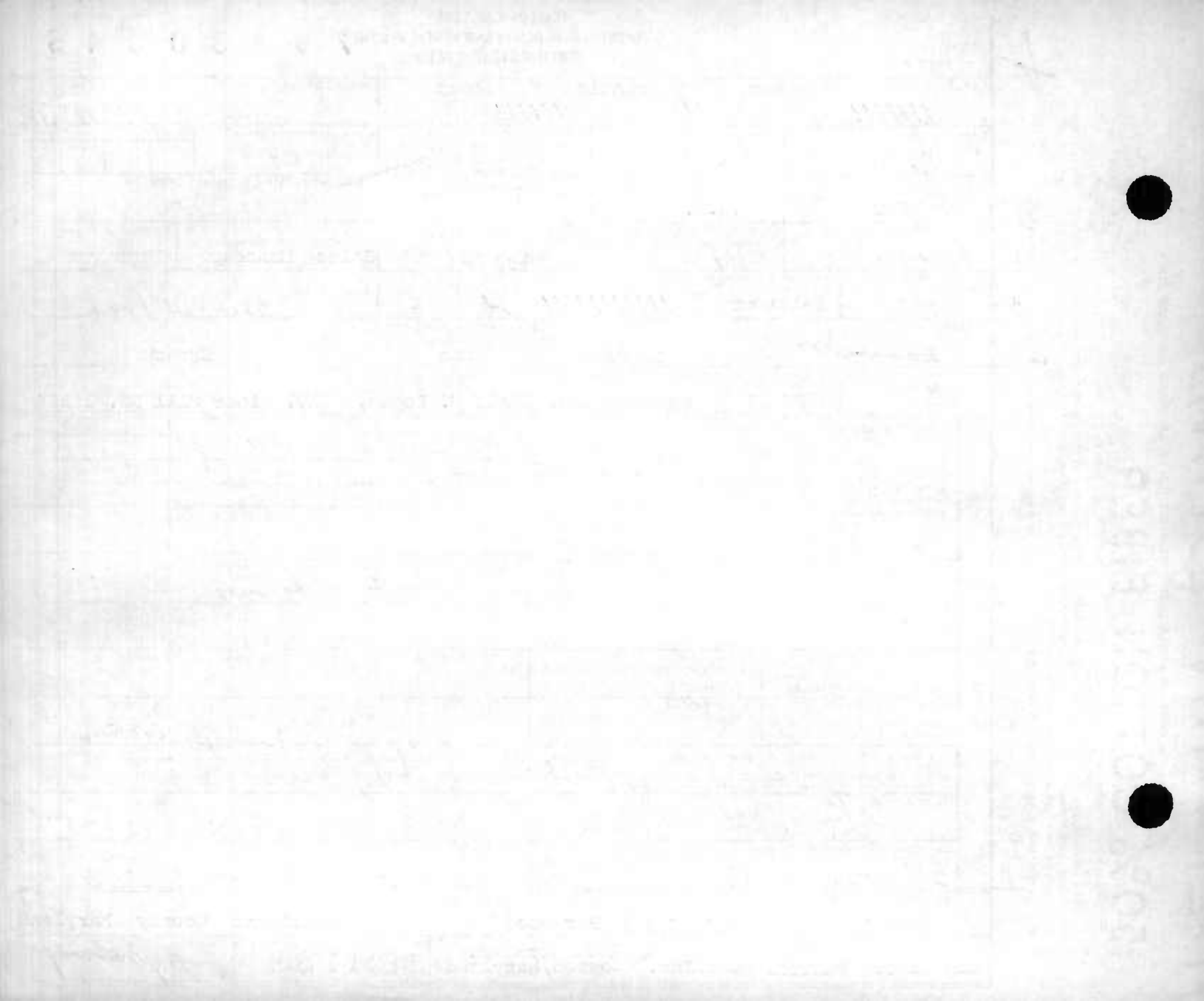
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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					7 9 3 0 3 4 5	
1- FOR STATE REGISTRAR			REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) John Francis Lopez			2a. DATE OF DEATH 12-7-79		2b. HOUR 10 <sup>10</sup> PM	
3. SEX MALE	4. RACE White	5. DATE OF BIRTH 1 22 20	6. AGE (IN YEARS LAST BIRTHDAY) 59 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD			
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Good Samaritan Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Sales Manager		12b. KIND OF BUSINESS OR INDUSTRY Magnavox
13a. STATE MD		13b. COUNTY Baltimore	13c. CITY OR TOWN Baltimore	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS 210 Cedar Mill Road	
14. FATHER'S NAME Joseph Lopez		15. MOTHER'S MAIDEN NAME Anna Cusack				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. WW II 103-01-2004		17. INFORMANT ADDRESS Elsie M. Lopez, 2107 Cider Mill Rd. 21234		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Advanced metastatic cancer of the stomach</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <u>Adrenal insufficiency due to metastases</u>						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from <u>12/6/79</u> , 19 <u>79</u> , to <u>12/7/79 10:10 PM</u> , that (I) (we) lost saw the deceased alive on <u>12/7/79</u> , 19 <u>79</u> , and that on (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE <u>Lothar L. Rivera, MD</u>				22c. DATE SIGNED 12/7/79		22d. PHYSICIAN'S NAME (TYPE OR PRINT) Lothar L. Rivera, MD
22e. ADDRESS Good Samaritan Hospital				22f. ADDRESS Baltimore County Maryland		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12/11/79		23c. NAME OF CEMETERY OR CREMATORY Parkwood		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore County Maryland
24. FUNERAL DIRECTOR NAME Ruck Towson Funeral Home, Inc.		24b. ADDRESS 1050 York Rd. Towson, Maryland		25a. DATE REC'D. BY REGISTRAR DEC 11 1979		25b. REGISTRAR'S SIGNATURE <u>Lothar L. Rivera</u>



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
1. FOR STATE REGISTRAR		7 9 3 0 3 4 6 REG. NO.									
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR	
Mildred D. LOUNDS								December 14, 1979		5:00A M	
3 SEX		4 RACE		5 DATE OF BIRTH MONTH DAY YEAR		6 AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.	
Female		Negro		9 6 1939		40 YRS.					
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH					
Washington, D. C.		U. S. A.				Baltimore City MD.					
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)						12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b KIND OF BUSINESS OR INDUSTRY	
Baltimore		Maryland General Hospital									
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a STATE		13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS?		13e STREET ADDRESS			
Maryland				Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		2416 Wilgray Court			
14 FATHER'S NAME FIRST MIDDLE LAST				15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST							
Norman Blackwell				Mattie M. Kent							
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)				16b SOCIAL SECURITY NO.				17 INFORMANT ADDRESS			
				216-34-4856				Mattie M. Reed 804 East 20th Street			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic Renal Failure</u> 585- DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a DATE OF OPERATION				19b CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY?		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
								YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK				21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				21f LOCATION STREET CITY OR TOWN COUNTY STATE			
22a I certify that <del>the</del> <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>November 10</u> , 19 <u>79</u> , to <u>December 14</u> , 19 <u>79</u> , that <del>we</del> <input checked="" type="checkbox"/> saw the deceased alive on <u>December 14</u> , 19 <u>79</u> , and that in <del>my</del> <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above <del>XX</del> (we) (did) <del>not</del> view the body after death.											
22b SIGNATURE				DEGREE				ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c DATE SIGNED	
<u>Darold Beard, M.D.</u>										12-14-79	
22d PHYSICIAN'S NAME (TYPE OR PRINT)				22e ADDRESS							
Darold Beard, M.D.				c/o Maryland General Hospital							
23a BURIAL, CREMATION, REMOVAL (SPECIFY)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION CITY OR TOWN		COUNTY		STATE	
Burial		12/20/1979		Mount Calvary Cemetery		Baltimore		Maryland			
24 FUNERAL DIRECTOR NAME ADDRESS				25a DATE REC'D BY REGISTRAR				25b REGISTRAR'S SIGNATURE			
Wm. C. March F/H 1101 East North Avenue				DEC 17 1979				<u>History McHenry</u>			

2001-2002

U. M. Wilson, Bristol, England

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										
1. FOR STATE REGISTRAR					7 9 3 0 3 4 7 REG. NO.					
1. DECEASED NAME (TYPE OR PRINT) <b>MARTHA JANE LOWRIMORE.</b>					2. DATE OF DEATH MONTH DAY YEAR <b>12-17-79</b>					2b. HOUR <b>8:15 P.M.</b>
3. SEX <b>FEMALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>7-3-95</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>84</b>		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>JASPER, ALABAMA</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>CITY BALTIMORE CITY, MD.</b>				
10. CITY OR TOWN OF DEATH <b>BALTIMORE, MD.</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>BALTIMORE CITY HOSPITALS</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>RETIRED</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>HOUSE WORK.</b>		
13a. STATE <b>MD.</b>		13b. COUNTY <b>-----</b>		13c. CITY OR TOWN <b>BALTIMORE</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>3418 TOONE ST. # 21224.</b>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>? JOHNSON</b>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>UNKNOWN</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>432-42-4352</b>		17. INFORMANT <b>BETTIE LOWRIMORE ;</b>		ADDRESS <b>3418 TOONE ST. BALTO. # 21224, MD.</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): <b>CARDIORESPIRATORY ARREST</b> <b>4292</b> DUE TO, OR AS A CONSEQUENCE OF (b): <b>Arteriosclerotic Cardiovascular disease</b> DUE TO, OR AS A CONSEQUENCE OF (c): APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (this hospital) attended the deceased from <b>4/1/78</b> , 19 <b>78</b> , to <b>12/17</b> , 19 <b>79</b> , that (we) lost the deceased alive on <b>12/17</b> , 19 <b>79</b> , and that in (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) did not view the body after death, so state.)										
22b. SIGNATURE <b>J. LAMANTIA</b>				DEGREE <b>MD</b> ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c. DATE SIGNED <b>12/17/79</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>J. LAMANTIA</b>				22e. ADDRESS <b>4940 Eastern Ave.</b>						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>12-20-79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>GLEN HAVEN MEM. PARK</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>RTICHEL HIGHWAY, A.A.CO., MD.</b>				
24. FUNERAL DIRECTOR NAME <b>Charles S. Seiler &amp; Son Inc</b>				901 S. CONKLING ST. BALTO., 21224, MD.		25a. DATE REC'D. BY REGISTRAR <b>DEC 24 1979</b>		25b. REGISTRAR'S SIGNATURE <b>Hester, Hester</b>		



2000 2001 2002 2003 2004 2005 2006 2007 2008 2009 2010 2011 2012 2013 2014 2015 2016 2017 2018 2019 2020 2021 2022 2023 2024 2025 2026 2027 2028 2029 2030 2031 2032 2033 2034 2035 2036 2037 2038 2039 2040 2041 2042 2043 2044 2045 2046 2047 2048 2049 2050 2051 2052 2053 2054 2055 2056 2057 2058 2059 2060 2061 2062 2063 2064 2065 2066 2067 2068 2069 2070 2071 2072 2073 2074 2075 2076 2077 2078 2079 2080 2081 2082 2083 2084 2085 2086 2087 2088 2089 2090 2091 2092 2093 2094 2095 2096 2097 2098 2099 2100 2101 2102 2103 2104 2105 2106 2107 2108 2109 2110 2111 2112 2113 2114 2115 2116 2117 2118 2119 2120 2121 2122 2123 2124 2125 2126 2127 2128 2129 2130 2131 2132 2133 2134 2135 2136 2137 2138 2139 2140 2141 2142 2143 2144 2145 2146 2147 2148 2149 2150 2151 2152 2153 2154 2155 2156 2157 2158 2159 2160 2161 2162 2163 2164 2165 2166 2167 2168 2169 2170 2171 2172 2173 2174 2175 2176 2177 2178 2179 2180 2181 2182 2183 2184 2185 2186 2187 2188 2189 2190 2191 2192 2193 2194 2195 2196 2197 2198 2199 2200 2201 2202 2203 2204 2205 2206 2207 2208 2209 2210 2211 2212 2213 2214 2215 2216 2217 2218 2219 2220 2221 2222 2223 2224 2225 2226 2227 2228 2229 2230 2231 2232 2233 2234 2235 2236 2237 2238 2239 2240 2241 2242 2243 2244 2245 2246 2247 2248 2249 2250 2251 2252 2253 2254 2255 2256 2257 2258 2259 2260 2261 2262 2263 2264 2265 2266 2267 2268 2269 2270 2271 2272 2273 2274 2275 2276 2277 2278 2279 2280 2281 2282 2283 2284 2285 2286 2287 2288 2289 2290 2291 2292 2293 2294 2295 2296 2297 2298 2299 2300 2301 2302 2303 2304 2305 2306 2307 2308 2309 2310 2311 2312 2313 2314 2315 2316 2317 2318 2319 2320 2321 2322 2323 2324 2325 2326 2327 2328 2329 2330 2331 2332 2333 2334 2335 2336 2337 2338 2339 2340 2341 2342 2343 2344 2345 2346 2347 2348 2349 2350 2351 2352 2353 2354 2355 2356 2357 2358 2359 2360 2361 2362 2363 2364 2365 2366 2367 2368 2369 2370 2371 2372 2373 2374 2375 2376 2377 2378 2379 2380 2381 2382 2383 2384 2385 2386 2387 2388 2389 2390 2391 2392 2393 2394 2395 2396 2397 2398 2399 2400 2401 2402 2403 2404 2405 2406 2407 2408 2409 2410 2411 2412 2413 2414 2415 2416 2417 2418 2419 2420 2421 2422 2423 2424 2425 2426 2427 2428 2429 2430 2431 2432 2433 2434 2435 2436 2437 2438 2439 2440 2441 2442 2443 2444 2445 2446 2447 2448 2449 2450 2451 2452 2453 2454 2455 2456 2457 2458 2459 2460 2461 2462 2463 2464 2465 2466 2467 2468 2469 2470 2471 2472 2473 2474 2475 2476 2477 2478 2479 2480 2481 2482 2483 2484 2485 2486 2487 2488 2489 2490 2491 2492 2493 2494 2495 2496 2497 2498 2499 2500 2501 2502 2503 2504 2505 2506 2507 2508 2509 2510 2511 2512 2513 2514 2515 2516 2517 2518 2519 2520 2521 2522 2523 2524 2525 2526 2527 2528 2529 2530 2531 2532 2533 2534 2535 2536 2537 2538 2539 2540 2541 2542 2543 2544 2545 2546 2547 2548 2549 2550 2551 2552 2553 2554 2555 2556 2557 2558 2559 2560 2561 2562 2563 2564 2565 2566 2567 2568 2569 2570 2571 2572 2573 2574 2575 2576 2577 2578 2579 2580 2581 2582 2583 2584 2585 2586 2587 2588 2589 2590 2591 2592 2593 2594 2595 2596 2597 2598 2599 2600 2601 2602 2603 2604 2605 2606 2607 2608 2609 2610 2611 2612 2613 2614 2615 2616 2617 2618 2619 2620 2621 2622 2623 2624 2625 2626 2627 2628 2629 2630 2631 2632 2633 2634 2635 2636 2637 2638 2639 2640 2641 2642 2643 2644 2645 2646 2647 2648 2649 2650 2651 2652 2653 2654 2655 2656 2657 2658 2659 2660 2661 2662 2663 2664 2665 2666 2667 2668 2669 2670 2671 2672 2673 2674 2675 2676 2677 2678 2679 2680 2681 2682 2683 2684 2685 2686 2687 2688 2689 2690 2691 2692 2693 2694 2695 2696 2697 2698 2699 2700 2701 2702 2703 2704 2705 2706 2707 2708 2709 2710 2711 2712 2713 2714 2715 2716 2717 2718 2719 2720 2721 2722 2723 2724 2725 2726 2727 2728 2729 2730 2731 2732 2733 2734 2735 2736 2737 2738 2739 2740 2741 2742 2743 2744 2745 2746 2747 2748 2749 2750 2751 2752 2753 2754 2755 2756 2757 2758 2759 2760 2761 2762 2763 2764 2765 2766 2767 2768 2769 2770 2771 2772 2773 2774 2775 2776 2777 2778 2779 2780 2781 2782 2783 2784 2785 2786 2787 2788 2789 2790 2791 2792 2793 2794 2795 2796 2797 2798 2799 2800 2801 2802 2803 2804 2805 2806 2807 2808 2809 2810 2811 2812 2813 2814 2815 2816 2817 2818

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY REVISION IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM. 3. REMAINING PAGES 1 AND 2 SHOULD BE RETURNED WITHIN 72 HOURS TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE RETURNED TO THE DIVISION OF VITAL RECORDS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										30348			
FOR 1- STATE REGISTRAR										REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Harry Issac Ludwig										2a. DATE KNOWN OF DEATH ESTIMATED MONTH DAY YEAR 12 15 79		2b. HOUR M P. M.	
3. SEX male		4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR 12/5/16		6. AGE (IN YEARS) (LAST BIRTHDAY) YRS. 63		IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		7c. DATE PRONOUNCED DEAD MONTH DAY YEAR 12 15 79		2d. HOUR P. M. 4:35	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Baltimore, Md.				7b. CITIZEN OF WHAT COUNTRY? U.S.A.				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.			
10. CITY OR TOWN OF DEATH Baltimore				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 3302 Hayward Avenue				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Plumber		12b. KIND OF BUSINESS OR INDUSTRY Plumbing			
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)										13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 3302 Hayward Avenue	
13a. STATE Md		13b. COUNTY ---		13c. CITY OR TOWN Baltimore		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Clara Crambitt		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No ---		16b. SOCIAL SECURITY NO. 215-12-4672		17. INFORMANT ADDRESS Catonsville, Maryland 21228 Kenneth W. Hipsley-23 Ridge Road	
14. FATHER'S NAME FIRST MIDDLE LAST John A. Ludwig										15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Clara Crambitt			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: Arteriosclerotic cardiovascular disease IMMEDIATE CAUSE (a) 4392 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ (c) _____ DUE TO, OR AS A CONSEQUENCE OF										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .													
ACTUAL SIGNATURE Hormez R. Guard				TITLE (SPECIFY) Assistant				DATE SIGNED 12/16/79					
EXAMINER'S NAME (TYPE OR PRINT) Hormez R. Guard, M.D.				ADDRESS 111 Penn St. Balto., MD 21201									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 12/21/79		23c. NAME OF CEMETERY OR CREMATORY Druid Ridge Cemetery				23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Maryland			
24. FUNERAL DIRECTOR'S NAME Sterling Funeral Estate 736 Edmondson Ave.				25a. DATE REC'D. BY REGISTRAR DEC 24 1979				25b. REGISTRAR'S SIGNATURE L. J. McCreedy					



DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH7 9 3 0 3 4 9  
REG. NO.1- FOR  
STATE  
REGISTRAR

1 DECEASED NAME (TYPE OR PRINT) <b>HERBERT D Ludwig</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>12-3-79</b>			2b. HOUR <b>2<sup>25</sup> A.M.</b>			
3 SEX <b>male</b>		4. RACE <b>white</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Feb. 24, 1914</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>65</b> YRS.		7 IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. <b>12 3 79</b>	
7a. BIRTHPLACE (COUNTRY) <b>Penna.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>CITY</b> MD.			
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Lutheran Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Mfg.</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Maintenance</b>			
13a. STATE <b>Maryland</b>		13b. COUNTY <b>A.A.</b>		13c. CITY OR TOWN <b>Glen Burnie</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>405 Secluded Post Circle</b>	
14 FATHER'S NAME FIRST MIDDLE LAST <b>Clifford C. Ludwig</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Minnie Good</b>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>yes WW 2</b>		16b. SOCIAL SECURITY NO. <b>172-03-5530</b>		17. INFORMANT <b>Anna J. Ludwig</b>	
18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>ASPIRATION PNEUMONIA</b> <b>1629</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>OAT CELL CARCINOMA</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) <b>2 1/2 mos.</b>		PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>12/3 79</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>9/25</b> , 19 <b>79</b> , to <b>12/3</b> , 19 <b>79</b> , that (I) (we) last saw the deceased alive on <b>12/3</b> , 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.		22b. SIGNATURE <b>Edward Kozm</b>		DEGREE <b>EDWARD KOZM MD.</b>		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>12/3/79</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS							
<b>EDWARD KOZM MD.</b>		<b>LUTHERAN HOSP. BALT. MD.</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>burial</b>		23b. DATE <b>12/5/79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Crest Lawn Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Sikeville Carroll Maryland</b>			
24 FUNERAL DIRECTOR NAME ADDRESS <b>Ambrose Funeral Home, Inc 1328 Sulphur Spring Rd</b>		25a. DATE REC'D. BY REGISTRAR		25b. SIGNATURE <b>DEC 3 1979</b>					

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

7 9 3 0 3 5 0

REG. NO.

FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <i>Julia Ann Lupton</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>Dec. 6 1979</i>			2b. HOUR <i>2:55 A.M.</i>	
3. SEX <i>female</i>		4. RACE <i>white</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>12 2 54</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>25</i> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Maryland</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Baltimore City</i> MD.	
10. CITY OR TOWN OF DEATH <i>Baltimore</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Baltimore City Hospitals</i>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>never-worked</i>	
13a. STATE <i>Maryland</i>				13b. COUNTY <i>Baltimore</i>		13c. CITY OR TOWN <i>Baltimore</i>	
14. FATHER'S NAME FIRST MIDDLE LAST <i>Allen Lupton</i>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Elizabeth Lupton</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>no</i>		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <i>Teresa Lupton 2804 York Way Apt C</i>			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) *Upper airway Obstruction*APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH*10 minutes*

DUE TO, OR AS A CONSEQUENCE OF

(b) *Come and pneumonia**18 days*

DUE TO, OR AS A CONSEQUENCE OF

(c) *Cardiopulmonary arrest after aspiration**18 days*

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

*Seizure disorder, Severe mental retardation, microcephaly*

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <i>Nov. 17</i> , 19 <i>79</i> , to <i>Dec. 6</i> , 19 <i>79</i> , that (I) (we) lost saw the deceased alive on <i>Dec. 6</i> , 19 <i>79</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>T. H. Lin</i>				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <i>12/6/79</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>T. H. LIN</i>				22e. ADDRESS <i>Baltimore City Hospitals</i>			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>n Burial</i>		23b. DATE <i>12/10/79</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Sacred Heart Of Jesus</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Baltimore Maryland</i>	
24. FUNERAL DIRECTOR NAME ADDRESS <i>Walter Dabrowski 1005 Dundalk Avenue</i>				25a. DATE REC'D. BY REGISTRAR <i>DEC 10 1979</i>		25b. REGISTRAR'S SIGNATURE <i>Robert McCreary</i>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. For a family be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1005 Lindal Avenue.

12/10/74 Section 4111 1.55

## Synthesis

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

1. FOR STATE REGISTRAR		STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH		7 9 3 0 3 5 1 REG. NO.	
1 DECEASED NAME (TYPE OR PRINT) FIRST ANNA MARGARET LUTZ MARGARET Ann Lutz		2a DATE OF DEATH MONTH DAY YEAR December 11, 1979		2b HOUR 8:45 PM	
3 SEX Female	4 RACE White	5 DATE OF BIRTH MONTH DAY YEAR April 4, 1911		6 AGE (IN YEARS LAST BIRTHDAY) 68 YRS.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b CITIZEN OF WHAT COUNTRY? U S A	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.	
10 CITY OR TOWN OF DEATH Baltimore	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Maryland General Hospital		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retail Sales		12b KIND OF BUSINESS OR INDUSTRY Retired
13a STATE Maryland		13b COUNTY Baltimore	13c CITY OR TOWN Catonsville	13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14 FATHER'S NAME FIRST MIDDLE LAST Lawrence L. Schwartz		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Schmidt			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b SOCIAL SECURITY NO 220-14-9268		17 INFORMANT ADDRESS W. Elmer Lutz, 1017 Southridge Rd.	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a). <u>Gastrointestinal Cancer</u> <u>1599</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____					
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION CITY OR TOWN COUNTY STATE	
22a I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>December 4</u> 19 <u>79</u> to <u>December 11</u> 19 <u>79</u> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>December 11</u> 19 <u>79</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) (did) (did not) view the body after death.					
22b SIGNATURE <u>Harvey Mishner</u>		DEGREE MD		22c DATE SIGNED 12-11-79	
22d PHYSICIAN'S NAME (TYPE OR PRINT) Harvey Mishner, M.D.		22e ADDRESS c/o Maryland General Hospital			
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b DATE 12/14/79		23c NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery	
23d LOCATION CITY OR TOWN Baltimore,		COUNTY Maryland		STATE	
24 FUNERAL DIRECTOR NAME 1630 Edmondson Ave. Catonsville, Md Witzke Funeral Home of Catonsville, P.A. 21228		25a DATE REC'D. BY REGISTRAR DEC 13 1979		25b REGISTRAR'S SIGNATURE <u>Robert A. Kelly</u>	



1200



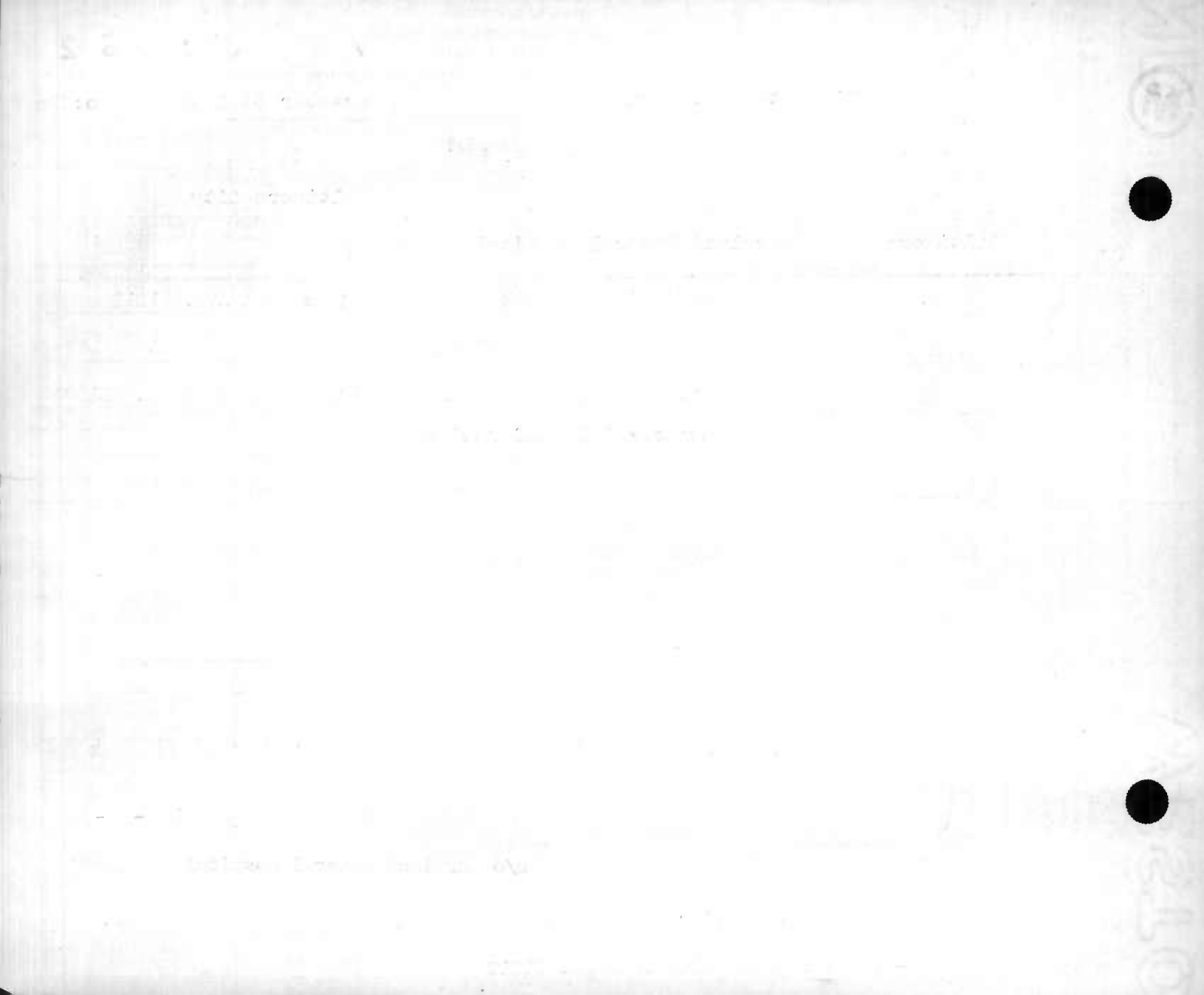


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1 - FOR STATE REGISTRAR		REG. NO. 7930352							
1 DECEASED NAME (TYPE OR PRINT)		FIRST Elizabeth		MIDDLE B.		LAST Lyng		2a DATE OF DEATH MONTH DAY YEAR	
								December 30 1979	
3 SEX		4 RACE		5 DATE OF BIRTH MONTH DAY YEAR		6 AGE (IN YEARS LAST BIRTHDAY)		7b HOUR	
FEMALE		WHITE		JULY 2, 1901		78 YRS		10:27 AM	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH			
MARYLAND		USA				Baltimore City MD.			
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b KIND OF BUSINESS OR INDUSTRY	
Baltimore		Maryland General Hospital				CLERK		SALES	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13a STATE		13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS?	
		MD.				BALTIMORE		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14 FATHER'S NAME		15 MOTHER'S MAIDEN NAME		13e STREET ADDRESS					
FIRST MIDDLE LAST		FIRST MIDDLE LAST		502 WINSTON AVE. 21212					
JAMES		ELIZABETH							
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b SOCIAL SECURITY NO.		17 INFORMANT		ADDRESS			
NO		214-22-1319A		MARIE L. VANIK		1436 NORTH BEND RD. 21084			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: Myocardial Infarction									
IMMEDIATE CAUSE (a) 410- DUE TO, OR AS A CONSEQUENCE OF									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF									
(c)									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY?		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
				YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
		P.M. 19							
21d INJURY OCCURRED		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION					
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK				STREET CITY OR TOWN COUNTY STATE					
22a I certify that (I) (This hospital) attended the deceased from December 28, 1979, to December 30, 1979, that (I) (we) last saw the deceased alive on December 28, 1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b SIGNATURE		DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c DATE SIGNED			
Dr. James A. Towles		MD				12-30-79			
22d PHYSICIAN'S NAME (TYPE OR PRINT)		22e ADDRESS							
Dr. JAMES COCKEY		c/o Maryland General Hospital							
23a BURIAL, CREMATION, REMOVAL (SPECIFY)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION CITY OR TOWN		COUNTY STATE	
BURIAL		JAN 2, 1980		NEW CATHEDRAL CEM.		BALTIMORE		MD.	
24 FUNERAL DIRECTOR NAME		ADDRESS		25a DATE REC'D. BY REGISTRAR		25b REGISTRAR'S SIGNATURE			
MITCHELL-WIEDEFELD HOME		6500 YORK RD. 21212		JAN 4 1980		[Signature]			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP \_\_\_\_\_

DHMM-16 20M  
(VRA 15, 4) 7/78

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		7 9 REG. NO. 3 0 3 5 3							
1. DECEASED NAME (TYPE OR PRINT) <b>Elmer C. Lyons, Sr.</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>12/ 1/ 79</b>		2b. HOUR <b>8 b</b> M			
3. SEX <b>Male</b>		4. RACE <b>Caucasian</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>April 2, 1925</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>54</b> YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>West Virginia</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY</b> MD.			
10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>ST AGNES HOSPITAL</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Shipping Clerk</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Goodyear Tires</b>			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Maryland</b>		13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Baltimore</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>4323 Annapolis Road 21227</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>James Lyons</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Rose Tyles</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE YEAR OR DATES) <b>235-34-0831</b>		17. INFORMANT <b>Baltimore, Maryland 21227</b> <b>Mrs. Jane V. Lyons 4323 Annapolis Road</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Cardiopulmonary arrest</b> <b>1629</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Concussion (R) laceration with acute</b> DUE TO, OR AS A CONSEQUENCE OF <b>Cardiopulmonary arrest</b> (c) _____ CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>C. Lyons</b>		DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>12/1/79</b>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>KYAW NYUNT</b>		22e. ADDRESS <b>900 CATON AVE BALTIMORE MD 21229</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>12/4/79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Louisa Park Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore Maryland</b>			
24. FUNERAL DIRECTOR NAME ADDRESS <b>Mc Cully Funeral Home of Brooklyn - Baltimore, Md. 21225</b>		25a. DATE REC'D. BY REGISTRAR <b>DEC 5 1979</b>		25b. REGISTRAR'S SIGNATURE <b>John A. Brady</b>					

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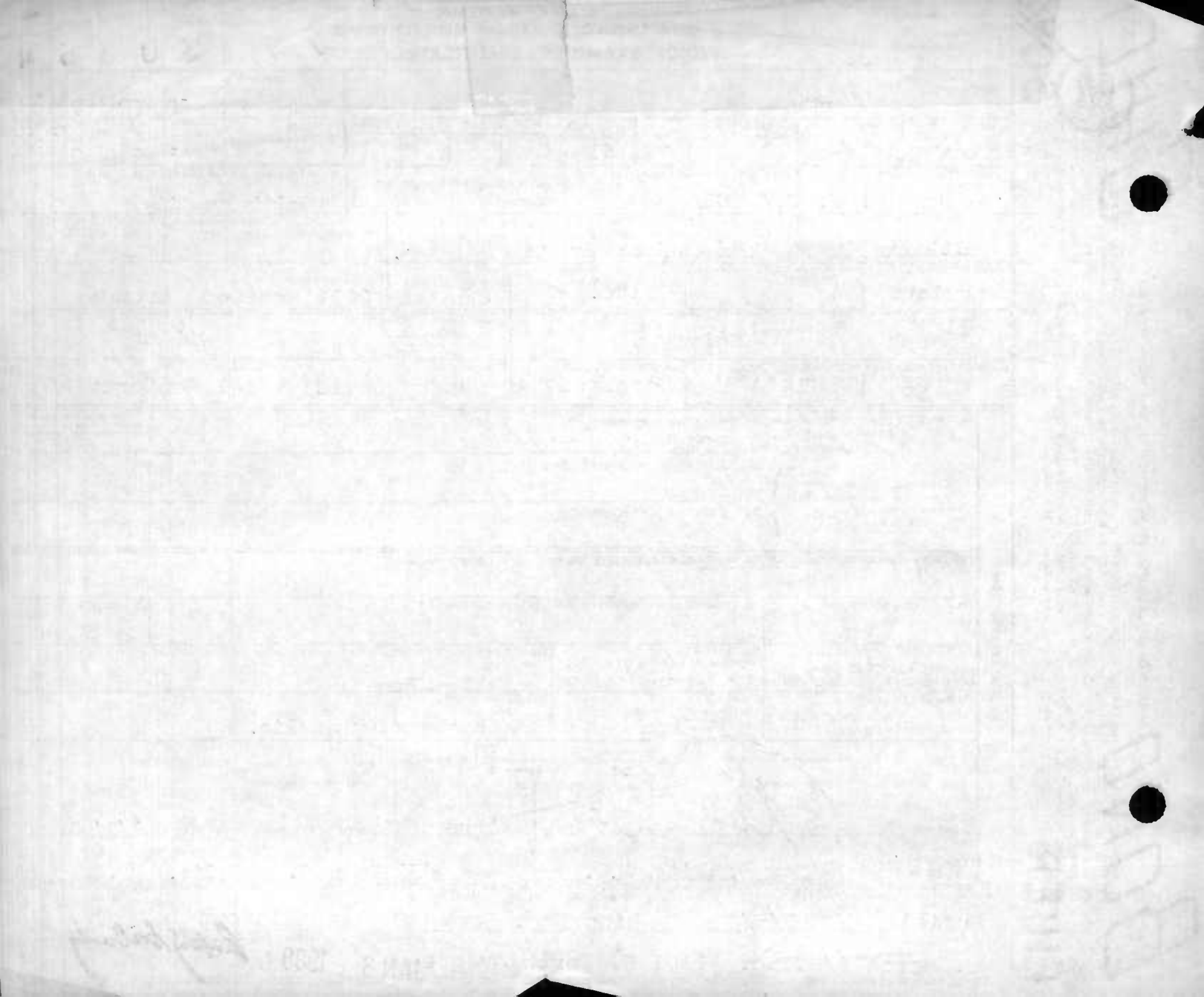
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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. GIVE PAGE 4 TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										9		30354	
1- STATE REGISTRAR										2a DATE KNOWN OF DEATH		2b HOUR	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Martha Mabin										2a DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> 12 30 19 79		2b HOUR M 1:12 PM	
3. SEX Female		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR 3 13 28		6. AGE (IN YEARS) LAST BIRTHDAY 51 YRS.		IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		7c. DATE PRONOUNCED DEAD MONTH DAY YEAR 1 2 19 80		7d. HOUR M 1:12 PM	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Rocky Mt. N. C.				7b. CITIZEN OF WHAT COUNTRY? USA				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City, MD.	
10. CITY OR TOWN OF DEATH Baltimore City				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 2926 Westwood Avenue				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Maryland				13b. COUNTY Balto.				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				13e. STREET ADDRESS 2926 Westwood Avenue	
14. FATHER'S NAME FIRST MIDDLE LAST Joseph Spivey						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Wilder							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No				16b. SOCIAL SECURITY NO. 220-22-7437				17. INFORMANT Sandra Davis				ADDRESS 3801 Monterey Rd	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Subdural hematoma</u> 888- Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) (c)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR ? P.M. 12 30 19 79				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART 1 OR PART 2) fell at home					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) home				21f. LOCATION STREET CITY OR TOWN COUNTY STATE 2926 Westwood Ave, Balto. MD					
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural cause <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>													
ACTUAL SIGNATURE Thomas D. Smith				TITLE (SPECIFY) M.D. Deputy Chief				DATE SIGNED 1/3/80					
EXAMINER'S NAME (TYPE OR PRINT) Thomas D. Smith, M.D.				ADDRESS 111 Penn St. Balto., MD.									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 1/5/80				23c. NAME OF CEMETERY OR CREMATORY King Mem. Park				23d. LOCATION CITY OR TOWN COUNTY STATE Randallstown Md.	
24. FUNERAL DIRECTOR NAME Wm. March F/H, Inc.				ADDRESS 1101 E. North Avenue				25a. DATE REC'D. BY REGISTRAR JAN 8 1980				25b. REGISTRAR'S SIGNATURE Robert Belady	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR 1 - STATE REGISTRAR		STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH		7 9 3 0 3 5 5 REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST FRANCIS A. MACHIN			2a. DATE OF DEATH MONTH DAY YEAR 12 25 79		2b. HOUR 3:22 P M
3 SEX MALE	4 RACE WHITE	5 DATE OF BIRTH MONTH DAY YEAR 07 09 1915		6. AGE (IN YEARS LAST BIRTHDAY) 64 63 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND	7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		
10 CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) ST. AGNES HOSPITAL -- E.R.		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) PAINTER		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE MARYLAND			13b. COUNTY ---	13c. CITY OR TOWN BALTIMORE	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST ISAAC MACHIN			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ELLEN BURNETT		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES		16b. SOCIAL SECURITY NO. WW II 215-10-9292		17. INFORMANT ADDRESS EMMA MACHIN 3620 CLARENELL ROAD, 21229	
18. CAUSE OF DEATH (Enter only one cause per line, (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac arrhythmia</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Coronary thrombosis - infarction</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Coronary arteriosclerosis</u>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>Phases under care of Dr. Earl Press</u> that (I) (we) last saw the deceased alive on <u>for above</u> 19 <u>Coronary Artery</u> death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
27b. SIGNATURE <u>William J. Bryson</u>			27c. DATE SIGNED 27 Dec 79		
27d. PHYSICIAN'S NAME (TYPE OR PRINT) WILLIAM J. BRYSON, M.D.			27e. ADDRESS 5772 WESTVIEW MALL		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 12-29-79		23c. NAME OF CEMETERY OR CREMATORY LOUDON PARK	
24. FUNERAL DIRECTOR NAME HUBBARD FUNERAL HOME, INC.		ADDRESS 21229 4107 WILKENS AVE.		25a. DATE REC'D. BY REGISTRAR DEC 28 1979	
25b. DATE REC'D. BY REGISTRAR		25c. REGISTRAR'S SIGNATURE <u>Robert McElroy</u>			

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

7 9 3 0 3 5 6

FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>DOROTHY R MacGREGOR</b>			2a. DATE OF DEATH MONTH <b>12</b> DAY <b>21</b> YEAR <b>79</b>			2b. HOUR <b>12:15 A.M.</b>					
3 SEX <b>FEMALE</b>		4 RACE <b>WHITE</b>		5. DATE OF BIRTH MONTH <b>10</b> DAY <b>20</b> YEAR <b>03</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>76</b> YRS		IF UNDER 1 YEAR MONTHS <b>0</b> DAYS <b>0</b>		IF UNDER 24 HRS HOURS <b>0</b> MIN <b>0</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MD</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>BALTO CITY</b> MD.					
10 CITY OR TOWN OF DEATH <b>BALTO CITY</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>So Balto Gen HOSP</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>NURSE</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>HOSPITAL</b>			

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>MD</b> 13b. COUNTY <b>BALTO CITY</b> 13c. CITY OR TOWN <b>BALTO</b>			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>111 5th AVE</b>	
14. FATHER'S NAME FIRST <b>JOSEPH</b> MIDDLE <b>?</b> LAST <b>RENNANN</b>			15. MOTHER'S MAIDEN NAME FIRST <b>MARTHA</b> MIDDLE <b>—</b> LAST <b>WILSON</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>214-38-3569</b>		17 INFORMANT ADDRESS <b>6 BURWOOD HAURE GRACE</b>		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIO PULMONARY ARREST</b> <b>410-</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>CARDIOGENIC SHOCK</b> conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <b>ACUTE ANTERO SEPTAL MYOCARDIAL INFARCTION</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>10 min</b> <b>10 HRS</b> <b>15 HRS</b>	
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PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I <b>HYPER TENSION</b> <b>OLD POSTEROLATERAL MYOCARDIAL INFARCT</b>	
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19a. DATE OF OPERATION <b>12-20</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>HYPER TENSION</b>		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>12-20</b> , 19 <b>79</b> , to <b>12-21</b> , 19 <b>79</b> , that (I) (we) lost saw the deceased alive on <b>12-21</b> , 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>JOSEPH J. MARTINEZ-O'HARA</b> M.D.				DEGREE <b>M.D.</b>		22c. DATE SIGNED <b>12-21-79</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>JOSEPH J. MARTINEZ-O'HARA</b>				22e. ADDRESS <b>3001 S. HANOVER</b>			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>DEC. 24, 1979</b>		23c. NAME OF CEMETERY OR CREMATORY <b>ECKHART CEMETERY</b>		23d. LOCATION CITY OR TOWN <b>ECKHART</b> COUNTY <b>MARYLAND</b> STATE <b>MD</b>	
24 FUNERAL DIRECTOR NAME <b>DORST FUNERAL HOME, FROSTBURG, MD.</b> ADDRESS				25a. DATE REC'D. BY REGISTRAR <b>DEC 28 1979</b>		25b. REGISTRAR'S SIGNATURE <b>notary in custody</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 2 retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

7 9 3 0 3 5 7

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <i>Howard George Mack</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>12-27-79</i>			2b. HOUR <i>9:30 A.M.</i>				
3. SEX <i>Male</i>		4. RACE <i>White</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>7-3-1913</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>66</i> YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Balto. Md.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Baltimore City</i> MD.				
10. CITY OR TOWN OF DEATH <i>Balto.</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Baltimore City Hospital</i>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Maintenance</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Dixie Mfg. Co.</i>		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <i>Md.</i>			13b. COUNTY <i>Balto.</i>		13c. CITY OR TOWN <i>Balto.</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <i>5801 Cedonia Ave. -21206</i>	
14. FATHER'S NAME FIRST MIDDLE LAST <i>John Mack</i>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Dora Hamer</i>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i>			16b. SOCIAL SECURITY NO. <i>213-05-3270</i>		17. INFORMANT ADDRESS <i>Lillian M. Mack - 5801 Cedonia Ave. -21206</i>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Hypertensive Cardio Vascular Disease</i> <i>4029</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Coronary Heart Failure, acute</i> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <i>19</i>			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <i>12/5</i> , 19 <i>79</i> , to <i>12/27</i> , 19 <i>79</i> , that (I) (we) last saw the deceased alive on <i>12/20</i> , 19 <i>79</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <i>Joseph B. Liberto</i> M.D.						DEGREE <i>MD</i>		22c. DATE SIGNED <i>12/28/79</i>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>JOSEPH B. LIBERTO, M.D.</i>						22e. ADDRESS <i>3508 BAY ST - Baltimore, Md 21224</i>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>			23b. DATE <i>12-30-79</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Gardens of Faith Cemetery, Balto. Md.</i>		23d. LOCATION CITY OR TOWN COUNTY STATE			
24. FUNERAL DIRECTOR NAME <i>John C. Miller Inc-6415 Belair Rd.-21206</i>						15a. DATE REC'D BY REGISTRAR 15b. REGISTRAR'S SIGNATURE <i>DEC 31 1979</i> <i>McCreedy</i>				



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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					REG. NO. 7 9 3 0 3 5 8					
1. FOR STATE REGISTRAR					2a. DATE OF DEATH MONTH DAY YEAR					
1. DECEASED NAME (TYPE OR PRINT) Anna E Mackessey					December 28, 1979					
3 SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR July 6, 1911		6. AGE (IN YEARS LAST BIRTHDAY) 68		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 74 HRS. HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Conn.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.				
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 4307 Mainfield Ave				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE Maryland					13b. COUNTY		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME ROCK Rock MIDDLE Zaakoes LAST					15. MOTHER'S MAIDEN NAME FIRST Alexandria MIDDLE LAST Makowski					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No					16b. SOCIAL SECURITY NO. 217-26-7050		17. INFORMANT ADDRESS Mrs Anna M Brauer 4307 Mainfield Ave			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1729 Widespread metastases from Malignant Melanoma								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 mos		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from Sept 4, 19 79, to Nov 16, 19 79, that (I) (we) lost saw the deceased alive on Nov. 16, 19 79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE E.B. SAMSON - Corvera, M.D.					DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			22c. DATE SIGNED 12/28/79		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) E.B. SAMSON - Corvera M.D.					22e. ADDRESS 5807 Hayford Rd Balto 21214					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12/31/79		23c. NAME OF CEMETERY OR CREMATORY Holy Redeemer		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Maryland				
24. FUNERAL DIRECTOR NAME Leonard J Ruck Inc. ADDRESS Baltimore, Maryland					25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE DEC 31 1979					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 13 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
1. FOR STATE REGISTRAR		7 9 3 0 3 5 9		REG. NO.							
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR	
Charles						MACKLIN		December 1 1999		1:58 P.M.	
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 74 HRS. HOURS MIN.	
Male		White		8 31 1896		83 <del>88</del>					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
RUSSIA		USA				Baltimore City MD.					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
Baltimore		Sinai Hospital				SALESMAN		FURNITURE			
13a. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>						13b. STREET ADDRESS					
						2500 W. Belvedere Ave Apt 810					
14. FATHER'S NAME FIRST MIDDLE LAST						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST					
ZELIG MACKLIN						MUSHA FINKELSTEIN					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS					
NO		577-48-9803		MRS. ELSIE LISS		6813 PIMLICO DR. ( 21209)					
18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cardiopulmonary arrest</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
514- <u>Cardiopulmonary arrest</u>										2 hrs	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last											
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Pulmonary edema</u>											
DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (this hospital) attended the deceased from <u>December 1, 19 99</u> to <u>December 1, 19 99</u> , that (we) lost (saw the deceased alive on <u>December 1, 19 99</u> , and that in (my) <input checked="" type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above, (I <input checked="" type="checkbox"/> did) <input type="checkbox"/> did not view the body after death.											
22b. SIGNATURE		DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED					
Arthur E. Bakal		MD				Dec 1, 1999					
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS							
Arthur E. BAKAL				Sinai Hosp. Belvedere & Greenspring							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE					
BURIAL		12/2/99		PETACH TIKVAH CONG.		ROSEDALE, MD.					
24. FUNERAL DIRECTOR NAME				25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
SOL LEVINSON & BROS. BALTO., MD. 21215				DEC 13 1979		[Signature]					







TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPARTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										
1. FOR STATE REGISTRAR					7 9 3 0 3 6 0 REG. NO.					
1. DECEASED NAME (TYPE OR PRINT) FIRST MARY MIDDLE P. LAST MACKOWIAK					2a. DATE OF DEATH MONTH 12 DAY 20 YEAR 79			2b. HOUR 208A		
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH MONTH 06 DAY 02 YEAR 13		6. AGE (IN YEARS LAST BIRTHDAY) 66 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) PENNSYLVANIA		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.				
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) JOHNS HOPKINS HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) SEAMSTRESS		12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MARYLAND 13b. COUNTY ---					13c. CITY OR TOWN BALTIMORE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 3625 McTAVISH AVENUE, 21229	
14. FATHER'S NAME FIRST JOSEPH MIDDLE --- LAST PETRUSKA					15. MOTHER'S MAIDEN NAME FIRST ELIZABETH MIDDLE --- LAST BARTOS					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO					16b. SOCIAL SECURITY NO. 181-01-8075		17. INFORMANT ADDRESS PETER P. MACKOWIAK, 3625 McTAVISH AVENUE			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Heart ruptures massive bleeding</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Left ventricular Heart rupture</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Open Heart Surgery</u> 3911 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): <u>Heart &amp; Arteries Heart disease with mitral stenosis</u>										
19a. DATE OF OPERATION 12/19/79			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED MITRAL DISEASE			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from 12/18, 19 79, to 12/20, 19 79, that (I) (we) last saw the deceased alive on 12/20/79, 19 79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE Gerhard H. MUNDINGER Jr.					DEGREE MD		22c. DATE SIGNED 12/20/79		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Gerhard H. MUNDINGER Jr.					22e. ADDRESS 601 N. Broadway					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE 12-24-79		23c. NAME OF CEMETERY OR CREMATORY LOUDON PARK		23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE CITY MARYLAND			
24. FUNERAL DIRECTOR NAME HUBBARD FUNERAL HOME, INC.			ADDRESS 21229 4107 WILKENS AVE.			25a. DATE REC'D. BY REGISTRAR 12/20/79		25b. REGISTRAR'S SIGNATURE R. F. H. H. H.		

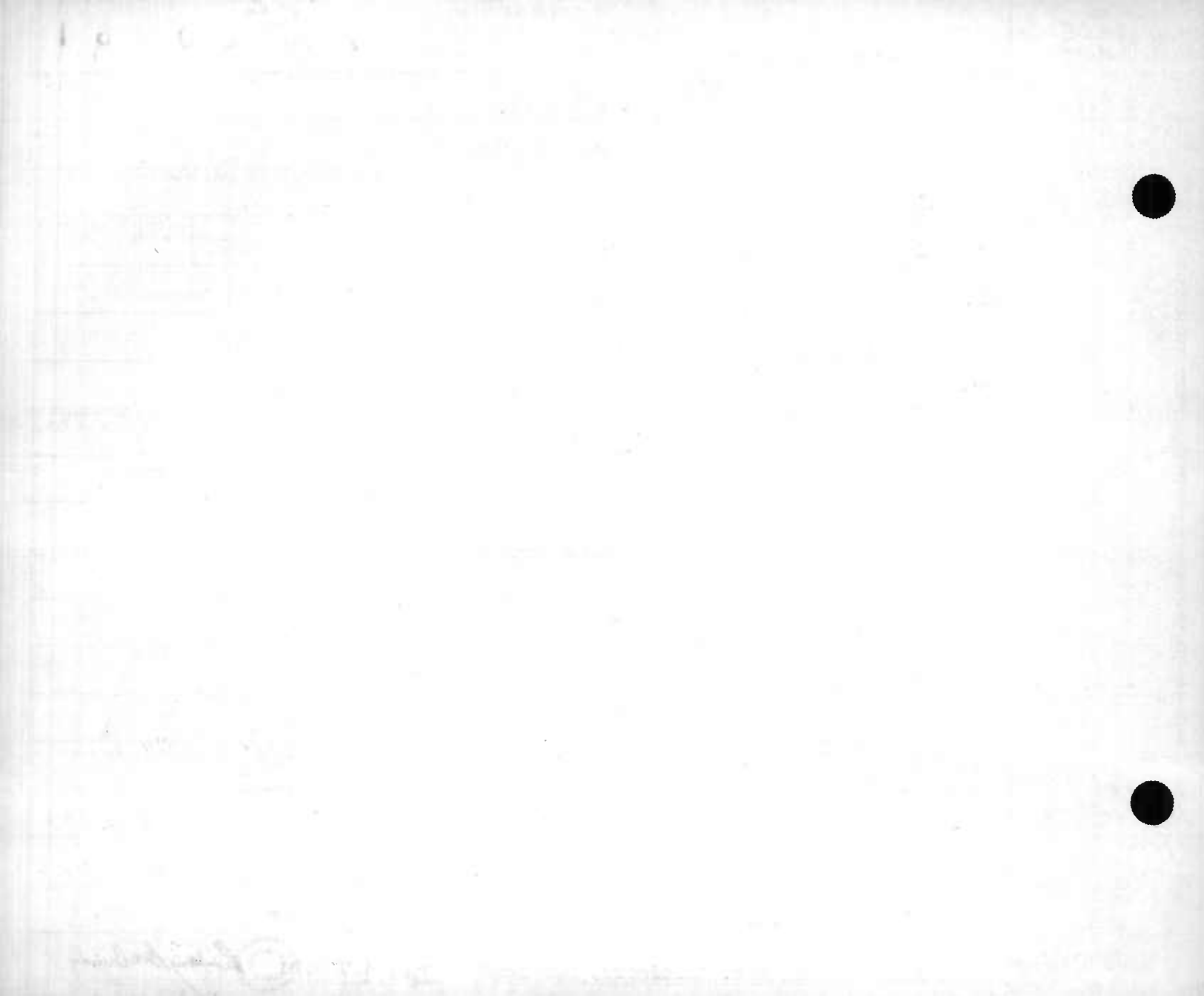


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1- FOR STATE REGISTRAR <i>Anna Magnaterra</i>									
1 DECEASED NAME (TYPE OR PRINT) <i>Anna Magnaterra</i>						2a DATE OF DEATH MONTH DAY YEAR <i>12-14-79</i>		2b HOUR <i>3:30</i> M	
3 SEX <i>Female</i>		4 RACE <i>White</i>		5 DATE OF BIRTH MONTH DAY YEAR <i>July 26, 1911</i>		6 AGE (IN YEARS LAST BIRTHDAY) <i>68</i> YRS		7 UNDER 1 YEAR MONTHS DAYS	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Italy</i>		7b CITIZEN OF WHAT COUNTRY? <i>USA</i>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <i>Balto City</i> MD.			
10 CITY OR TOWN OF DEATH <i>Baltimore</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Good Samaritan</i>				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Plastic Assembly</i>		12b KIND OF BUSINESS OR INDUSTRY	
13a STATE <i>Md.</i>		13b COUNTY		13c CITY OR TOWN <i>Baltimore</i>		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS <i>7019 Marietta Avenue</i>	
14 FATHER'S NAME FIRST MIDDLE LAST <i>Andrew DellaGatta</i>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Lucy Martaroni</i>					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>no</i>				16b SOCIAL SECURITY NO. <i>220-07-7909A</i>		17 INFORMANT ADDRESS <i>Mr. Nazzareno Magnaterra same</i>			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>CRONOPULMONARY ARREST</i> 1991 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: DUE TO, OR AS A CONSEQUENCE OF (b) <i>METASTATIC CARCINOMA</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>CRACINOMA</i> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>78 mos</i>								PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)	
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>PM 19</i>		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE					
22 I certify that (I) (this hospital) attended the deceased from <i>12/14/79</i> 19 <i>77</i> , to <i>12/18</i> 19 <i>79</i> , that (I) (we) lost saw the deceased alive on <i>12/13</i> 19 <i>79</i> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did not) view the body after death.									
22b SIGNATURE <i>Charles Hoersch</i>				DEGREE <i>MD</i> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c DATE SIGNED <i>12/14/79</i>	
22d PHYSICIAN'S NAME (TYPE OR PRINT) <i>CHARLES HOESCH</i>				22e ADDRESS <i>9712 BELAIR RD ; BALTO. MD. 21236</i>					
23a BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b DATE <i>Dec. 18, 1979</i>		23c NAME OF CEMETERY OR CREMATORY <i>Gardens of Faith</i>		23d LOCATION CITY/TOWN COUNTY STATE <i>Baltimore Md.</i>			
24 FUNERAL DIRECTOR NAME ADDRESS <i>Leonard J. Ruck Inc. Baltimore, Maryland</i>				25a DATE REC'D. BY REGISTRAR <i>DEC 17 1979</i>		25b REGISTRAR'S SIGNATURE <i>History Kelly</i>			

BP



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR THE FUNERAL DIRECTOR. PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 30362

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE KNOWN OF DEATH		ESTIMATED		MONTH		DAY		YEAR		2b. HOUR	
MARY		B.				MADDOX		12		2		19		79				M	
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YR.		IF UNDER 24 HRS.		7c. DATE PRONOUNCED DEAD		MONTH		DAY		YEAR		2d. HOUR	
female	negro	5 31 1906		73 YRS.						12		2		19		79		10pM	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED		NEVER MARRIED		WIDOWED		DIVORCED		9. BALTIMORE CITY OR COUNTY OF DEATH							
North Carolina		U. S. A.		MARRIED		NEVER MARRIED		WIDOWED		DIVORCED		Baltimore City MD.							
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY													
Baltimore		1102 E. Preston St.																	
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS											
Maryland				Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		1102 East Preston Street											
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME															
FIRST MIDDLE LAST				FIRST MIDDLE LAST															
Bob Bagby				Rose															
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)				16b. SOCIAL SECURITY NO.				17. INFORMANT				ADDRESS							
				231-52-8175				Ernest Maddox				1102 East Preston Street							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)																			
PART I DEATH WAS CAUSED BY: Arteriosclerotic cardiovascular disease																			
IMMEDIATE CAUSE (a) 4392																			
DUE TO, OR AS A CONSEQUENCE OF																			
(b)																			
DUE TO, OR AS A CONSEQUENCE OF																			
(c)																			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).																			
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY?							
												YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)											
				P.M. 19															
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION				CITY OR TOWN COUNTY STATE							
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .																			
ACTUAL SIGNATURE				TITLE (SPECIFY)				MEDICAL EXAMINER				DATE SIGNED							
Ann M. Dixon, M.D.				Assistant								12-3-79							
EXAMINER'S NAME (TYPE OR PRINT)				ADDRESS															
Ann M. Dixon, M.D.				111 Penn St.															
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE				23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION CITY OR TOWN COUNTY STATE							
Burial				12/8/1979				Church Cemetery				Granville Co., North Carolina							
24. FUNERAL DIRECTOR NAME				ADDRESS				25a. DATE REC'D. BY REGISTRAR				25b. REGISTRAR'S SIGNATURE							
Wm. C. March F/H				1101 East North Avenue				DEC 5 1979				History/History							

S e c t o r

ARMY

HEADQUARTERS

OFFICE OF THE ADJUTANT GENERAL

WASHINGTON, D. C.

1-1-41

1-1-41

1-1-41

1-1-41

*Handwritten signature*

1-1-41

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										
1- STATE REGISTRAR					79 30363 REG. NO.					
1. DECEASED NAME (TYPE OR PRINT) LAWRENCE FRANCIS MAINE					2a. DATE OF DEATH 12/12/79			2b. HOUR 3:40 PM		
3 SEX Male		4 RACE White		5. DATE OF BIRTH 11/20/1915		6. AGE (IN YEARS LAST BIRTHDAY) 64 YRS		IF UNDER 1 YEAR MONTHS DAYS		
7a. BIRTHPLACE (COUNTRY) Connecticut		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.				
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Baltimore City Hospitals				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Stallman		12b. KIND OF BUSINESS OR INDUSTRY Steel Mfgr.		
13a. STATE Maryland					13b. COUNTY Balto.		13c. CITY OR TOWN Dundalk		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14 FATHER'S NAME George Maine					15. MOTHER'S MAIDEN NAME Martha Chapman					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. (IF YES, GIVE WAR OR DATES) WW II		17. SOCIAL SECURITY NO. 217.16.8269		17. INFORMANT ADDRESS Mary L. Maine---Same as 13e				
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u> <u>4281</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>L V Failure</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (1) (this hospital) attended the deceased from _____, 19____, to <u>Dec 12</u> , 19 <u>79</u> , that (1) (we) last saw the deceased alive on <u>Dec 12</u> , 19 <u>79</u> , and that it (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) not view the body after death.										
22b. SIGNATURE <u>Henry Taylor MD</u>					DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			22c. DATE SIGNED <u>12/12/79</u>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Henry Taylor</u>					22e. ADDRESS <u>BCIH</u>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 12/14/1979		23c. NAME OF CEMETERY OR CREMATORY Green Mount		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Md.				
24. FUNERAL DIRECTOR NAME Walter Brooks Bradley Inc Dundalk Md					25a. DATE REC'D. BY REGISTRAR DEC 17 1979		25b. REGISTRAR'S SIGNATURE <u>Henry McCreedy</u>			

BP









TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

79 30364  
REG. NO.

1. FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>Lawrence</b>		FIRST <b>MANLEY</b>		LAST		2a. DATE OF DEATH MONTH DAY YEAR <b>December 10 1979</b>		2b. HOUR <b>9:15A M</b>	
3 SEX <b>Male</b>		4 RACE <b>NEGROID</b>		5 DATE OF BIRTH MONTH DAY YEAR <b>Feb. 28, 1883</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>96</b> YRS		IF UNDER 1 YEAR MONTHS DAYS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>North Carolina</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD			
10 CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Maryland General Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Retired</b>		12b. KIND OF BUSINESS OR INDUSTRY	

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Md.</b>		13b. COUNTY <b>Balto.</b>		13c. CITY OR TOWN <b>Balto.</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>1424 E. Federal St.</b>	
14 FATHER'S NAME FIRST MIDDLE LAST <b>William Manley</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>IDA ?</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES) <b>436-09-5498</b>		17 INFORMANT ADDRESS <b>Sally Parker 1424 E. Federal St.</b>					

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <b>Pneumonia</b> <b>2880</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>Leukopenia</b> DUE TO, OR AS A CONSEQUENCE OF (c)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
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PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			

22a. I certify that (he (this hospital) attended the deceased from <b>December 10, 1979</b> , to <b>December 10, 1979</b> , that <b>XX</b> (we) lost saw the deceased alive on <b>December 10, 1979</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above (we) did (did not) view the body after death.		22b. SIGNATURE <b>Darold Beard, MD</b>		DEGREE <b>M.D.</b>		22c. DATE SIGNED <b>12-10-79</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Darold Beard, M.D.</b>		22e. ADDRESS <b>c/o Maryland General Hospital</b>					

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>12-12-79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Calvary Cem.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Brook Park County Md.</b>	
24 FUNERAL DIRECTOR NAME <b>Calvin B. Scruggs Sr.</b>		ADDRESS <b>1412 E. O Preston St.</b>		25a. DATE REC'D. BY REGISTRAR <b>DEC 11 1979</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>	

1930

Baltimore  
 Maryland General Hospital  
 Baltimore City  
 December 10 1930

Mr. J. B. ...  
 1124 E. Federal St.  
 Baltimore, Md.  
 December 10 1930

Received 12-12-30  
 Mr. J. B. ...  
 1124 E. Federal St.  
 Baltimore, Md.  
 December 10 1930

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. GIVE PAGE 4 TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILE. IF THE DEATH IS SUSPECTED TO BE A BUREAU OF INVESTIGATION CASE, THE CERTIFICATE SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILE. IF THE DEATH IS SUSPECTED TO BE A BUREAU OF INVESTIGATION CASE, THE CERTIFICATE SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILE. IF THE DEATH IS SUSPECTED TO BE A BUREAU OF INVESTIGATION CASE, THE CERTIFICATE SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILE.

FOR STATE REGISTRAR										DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 30365	
1. DECEASED NAME (TYPE OR PRINT) <b>JAMES E. MANN</b>										2a. DATE KNOWN OF DEATH ESTI- MATED <input checked="" type="checkbox"/> MONTH DAY YEAR <b>12 13 79</b>										2b. HOUR <b>2:13</b>	
3. SEX <b>male</b>		4. RACE <b>black</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>3 12 56</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>23 YRS.</b>		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN		7c. DATE PRONOUNCED DEAD MONTH DAY YEAR <b>12 13 79</b>		2d. HOUR <b>12 13 79</b>							
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Md.</b>				7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b>				MD.					
10. CITY OR TOWN OF DEATH <b>Baltimore</b>				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SICKLE, CLINIC, OR STREET ADDRESS) <b>400 blk. 21 1/2 Street</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY									
13a. STATE <b>Md.</b>										13b. COUNTY		13c. CITY OR TOWN <b>Balto.</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>442 E. 22nd St.</b>					
14. FATHER'S NAME FIRST MIDDLE LAST <b>Samuel Mann</b>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Beatrice</b>					16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>No</b>					16b. SOCIAL SECURITY NO. <b>220-64-9272</b>						
17. INFORMANT <b>Patricia D. Mann</b>					ADDRESS <b>748 McCabe Avenue</b>																
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: <b>Gunshot wounds of head (unspecified)</b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
IMMEDIATE CAUSE (a) <b>9654</b> DUE TO, OR AS A CONSEQUENCE OF																					
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.																					
(b) <b>9654</b> DUE TO, OR AS A CONSEQUENCE OF																					
(c)																					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).																					
19a. DATE OF OPERATION					19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?					20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH					21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>2:00 PM 12-13 79</b>					21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) <b>shot by assailant(s)</b>											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK					21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <b>street</b>					21f. LOCATION CITY OR TOWN COUNTY STATE <b>400blk. . 21 1/2 St. Baltimore, Maryland</b>											
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> .																					
ACTUAL SIGNATURE <b>Margaret DeLoe</b>					TITLE (SPECIFY) <b>Assistant</b>					DATE SIGNED <b>12/13/79</b>											
EXAMINER'S NAME (TYPE OR PRINT) <b>Margarita A. Korell, M.D.</b>					ADDRESS <b>111 Penn Street</b>																
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>					23b. DATE <b>11/21/79</b>					23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Calvary Cem.</b>											
23d. LOCATION CITY OR TOWN COUNTY STATE <b>Ann Arundel Co., Md.</b>					23e. DATE RECEIVED BY REGISTRAR <b>DEC 21 1979</b>					23f. REGISTRAR'S SIGNATURE <b>Patricia D. Mann</b>											
24. FUNERAL DIRECTOR NAME <b>Wm C March F/H</b>					ADDRESS <b>1101 E. North Ave.</b>																

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death, and retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR	
AGOSTINO		MANULI						DEC. 3, 1979		M	
3 SEX		4 RACE		5 DATE OF BIRTH MONTH DAY YEAR		6 AGE (IN YEARS LAST BIRTHDAY) YRS		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN	
M		W		9/17/37		92					
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH					
ITALY		USA				BALTO. CITY MD					
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)						12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b KIND OF BUSINESS OR INDUSTRY	
BALTO		500 N. STREEPER ST.						COOK			
13a RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b STATE				13c CITY OR TOWN		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS			
MD				BALTO		YES		500 N. STREEPER			
14 FATHER'S NAME FIRST MIDDLE LAST				15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST							
SALVATORE MANULI				PAOLA LOGIUDICE							
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)				16b SOCIAL SECURITY NO		17 INFORMANT				ADDRESS	
UNK				216360588		MARIA MANULI				67 BOVE	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebral vascular accident</u> <u>436-</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Emphysema</u>											
19a DATE OF OPERATION				19b CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE					
22a I certify that (I) (this hospital) attended the deceased from <u>3-6</u> 19 <u>60</u> to <u>12-1</u> 19 <u>79</u> , that (I) (we) lost saw the deceased alive on <u>12-1</u> 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b SIGNATURE				DEGREE				ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c DATE SIGNED	
22d PHYSICIAN'S NAME (TYPE OR PRINT)				22e ADDRESS							
S. RUSSO MD				5722 Norfolk Rd Balto 21214							
23a BURIAL, CREMATION, REMOVAL (SPECIFY)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION CITY OR TOWN COUNTY STATE					
BURIAL		12/7/79		NEW CATHEDRAL		BALTO. MD.					
24 FUNERAL DIRECTOR NAME ADDRESS				25a DATE REC'D. BY REGISTRAR				25b REGISTRAR'S SIGNATURE			
J.E. CONNELLY 300 MACE				DEC 7 1979				[Signature]			



14th Nov 1950

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

FOR 1- STATE REGISTRAR										DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 30367	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Dora Marable (Marble)						2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR 12 8 19 79						7b. HOUR M 7:18 A									
3. SEX Female		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR 11 25 20		6. AGE (IN YEARS) LAST BIRTHDAY 59 YRS.		IF UNDER 1 YR. MONTHS DAYS HOURS MIN		7c. DATE PRONOUNCED DEAD MONTH DAY YEAR 12 8 19 79		7d. HOUR A									
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland				7b. CITIZEN OF WHAT COUNTRY? U. S. A.				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City, MD.									
10. CITY OR TOWN OF DEATH Baltimore				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1241 Cliftview Avenue				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY									
13a. STATE Maryland				13b. COUNTY		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 1241 Cliftview Avenue											
14. FATHER'S NAME FIRST MIDDLE LAST Harry Patterson						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lavenia Jackson															
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)				16b. SOCIAL SECURITY NO. N/A		17. INFORMANT NAME ADDRESS Ellen Marable 1747 East North Avenue															
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypertensive and arteriosclerotic cardiovascular disease with dissecting aneurysm of thoracic aorta Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).																					
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)															
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE															
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .																					
ACTUAL SIGNATURE Virginia L. Dolan				TITLE (SPECIFY) Assistant				DATE SIGNED 12/8/79													
EXAMINER'S NAME (TYPE OR PRINT) Virginia L. Dolan, M.D.				ADDRESS 111 Penn Street																	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 12/12/1979		23c. NAME OF CEMETERY OR CREMATORY Mount Auburn Cemetery				23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Maryland											
24. FUNERAL DIRECTOR NAME Wm. C. March F/H 1101 East North Avenue						25a. DATE REC'D. BY REGISTRAR DEC 11 1979				25b. REGISTRAR'S SIGNATURE R. J. McCreedy											

II

Very truly  
yours



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at 97

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE									
1. FOR STATE REGISTRAR					7 9 3 0 3 6 8				
1. DECEASED NAME (TYPE OR PRINT)					2a. DATE OF DEATH				
MINNIE MARCOWIS					12 24 79 8:52 P				
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR	
FEMALE		CAUCASIAN		DEC. 25, 1899		79 YRS.		IF UNDER 24 HRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			
POLAND		USA				BALTIMORE CITY MD.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
BALTIMORE		SINAI HOSPITAL				HOUSEWIFE		AT HOME	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					13a. INSIDE CITY LIMITS?				
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS	
MARYLAND				BALTIMORE				APT. 608 2500 W. BELVEDERE #21215	
14. FATHER'S NAME					15. MOTHER'S MAIDEN NAME				
ISRAEL FISHMAN					UNKNOWN				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)					16b. SOCIAL SECURITY NO.		17. INFORMANT		
NO					216-32-7503		MR. AARON MARCOWIS 3317 OLYMPIA AVE. BALTO., MD 21215		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) Cardiac Arrest.									
DUE TO, OR AS A CONSEQUENCE OF (b) Polycystic kidney failure & v. tach.									
DUE TO, OR AS A CONSEQUENCE OF (c) Severe Aortic Stenosis. CORONARY ART. Disease.									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
						YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
			HOUR A.M. MONTH DAY YEAR						
21d. INJURY OCCURRED			21e. PLACE OF INJURY		21f. LOCATION				
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE					DEGREE			22c. DATE SIGNED	
D. S. PATEL.					MD.			12/24/79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)					22e. ADDRESS				
D. S. PATEL.					SINAI Hospital.				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION		
BURIAL			DEC. 26, 1979		CHIZUK AMUNO		BALTIMORE COUNTY MARYLAND		
24. FUNERAL DIRECTOR					25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
SOL LEVINSON & BROS., INC.					JAN 3 1980		[Signature]		
6010 REISTERSTOWN RD. BALTO., MD 21215									

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1921. 1922. 1923. 1924. 1925. 1926. 1927. 1928. 1929. 1930. 1931. 1932. 1933. 1934. 1935. 1936. 1937. 1938. 1939. 1940. 1941. 1942. 1943. 1944. 1945. 1946. 1947. 1948. 1949. 1950. 1951. 1952. 1953. 1954. 1955. 1956. 1957. 1958. 1959. 1960. 1961. 1962. 1963. 1964. 1965. 1966. 1967. 1968. 1969. 1970. 1971. 1972. 1973. 1974. 1975. 1976. 1977. 1978. 1979. 1980. 1981. 1982. 1983. 1984. 1985. 1986. 1987. 1988. 1989. 1990. 1991. 1992. 1993. 1994. 1995. 1996. 1997. 1998. 1999. 2000. 2001. 2002. 2003. 2004. 2005. 2006. 2007. 2008. 2009. 2010. 2011. 2012. 2013. 2014. 2015. 2016. 2017. 2018. 2019. 2020. 2021. 2022. 2023. 2024. 2025. 2026. 2027. 2028. 2029. 2030. 2031. 2032. 2033. 2034. 2035. 2036. 2037. 2038. 2039. 2040. 2041. 2042. 2043. 2044. 2045. 2046. 2047. 2048. 2049. 2050. 2051. 2052. 2053. 2054. 2055. 2056. 2057. 2058. 2059. 2060. 2061. 2062. 2063. 2064. 2065. 2066. 2067. 2068. 2069. 2070. 2071. 2072. 2073. 2074. 2075. 2076. 2077. 2078. 2079. 2080. 2081. 2082. 2083. 2084. 2085. 2086. 2087. 2088. 2089. 2090. 2091. 2092. 2093. 2094. 2095. 2096. 2097. 2098. 2099. 2100. 2101. 2102. 2103. 2104. 2105. 2106. 2107. 2108. 2109. 2110. 2111. 2112. 2113. 2114. 2115. 2116. 2117. 2118. 2119. 2120. 2121. 2122. 2123. 2124. 2125. 2126. 2127. 2128. 2129. 2130. 2131. 2132. 2133. 2134. 2135. 2136. 2137. 2138. 2139. 2140. 2141. 2142. 2143. 2144. 2145. 2146. 2147. 2148. 2149. 2150. 2151. 2152. 2153. 2154. 2155. 2156. 2157. 2158. 2159. 2160. 2161. 2162. 2163. 2164. 2165. 2166. 2167. 2168. 2169. 2170. 2171. 2172. 2173. 2174. 2175. 2176. 2177. 2178. 2179. 2180. 2181. 2182. 2183. 2184. 2185. 2186. 2187. 2188. 2189. 2190. 2191. 2192. 2193. 2194. 2195. 2196. 2197. 2198. 2199. 2200. 2201. 2202. 2203. 2204. 2205. 2206. 2207. 2208. 2209. 2210. 2211. 2212. 2213. 2214. 2215. 2216. 2217. 2218. 2219. 2220. 2221. 2222. 2223. 2224. 2225. 2226. 2227. 2228. 2229. 2230. 2231. 2232. 2233. 2234. 2235. 2236. 2237. 2238. 2239. 2240. 2241. 2242. 2243. 2244. 2245. 2246. 2247. 2248. 2249. 2250. 2251. 2252. 2253. 2254. 2255. 2256. 2257. 2258. 2259. 2260. 2261. 2262. 2263. 2264. 2265. 2266. 2267. 2268. 2269. 2270. 2271. 2272. 2273. 2274. 2275. 2276. 2277. 2278. 2279. 2280. 2281. 2282. 2283. 2284. 2285. 2286. 2287. 2288. 2289. 2290. 2291. 2292. 2293. 2294. 2295. 2296. 2297. 2298. 2299. 2300. 2301. 2302. 2303. 2304. 2305. 2306. 2307. 2308. 2309. 2310. 2311. 2312. 2313. 2314. 2315. 2316. 2317. 2318. 2319. 2320. 2321. 2322. 2323. 2324. 2325. 2326. 2327. 2328. 2329. 2330. 2331. 2332. 2333. 2334. 2335. 2336. 2337. 2338. 2339. 2340. 2341. 2342. 2343. 2344. 2345. 2346. 2347. 2348. 2349. 2350. 2351. 2352. 2353. 2354. 2355. 2356. 2357. 2358. 2359. 2360. 2361. 2362. 2363. 2364. 2365. 2366. 2367. 2368. 2369. 2370. 2371. 2372. 2373. 2374. 2375. 2376. 2377. 2378. 2379. 2380. 2381. 2382. 2383. 2384. 2385. 2386. 2387. 2388. 2389. 2390. 2391. 2392. 2393. 2394. 2395. 2396. 2397. 2398. 2399. 2400. 2401. 2402. 2403. 2404. 2405. 2406. 2407. 2408. 2409. 2410. 2411. 2412. 2413. 2414. 2415. 2416. 2417. 2418. 2419. 2420. 2421. 2422. 2423. 2424. 2425. 2426. 2427. 2428. 2429. 2430. 2431. 2432. 2433. 2434. 2435. 2436. 2437. 2438. 2439. 2440. 2441. 2442. 2443. 2444. 2445. 2446. 2447. 2448. 2449. 2450. 2451. 2452. 2453. 2454. 2455. 2456. 2457. 2458. 2459. 2460. 2461. 2462. 2463. 2464. 2465. 2466. 2467. 2468. 2469. 2470. 2471. 2472. 2473. 2474. 2475. 2476. 2477. 2478. 2479. 2480. 2481. 2482. 2483. 2484. 2485. 2486. 2487. 2488. 2489. 2490. 2491. 2492. 2493. 2494. 2495. 2496. 2497. 2498. 2499. 2500. 2501. 2502. 2503. 2504. 2505. 2506. 2507. 2508. 2509. 2510. 2511. 2512. 2513. 2514. 2515. 2516. 2517. 2518. 2519. 2520. 2521. 2522. 2523. 2524. 2525. 2526. 2527. 2528. 2529. 2530. 2531. 2532. 2533. 2534. 2535. 2536. 2537. 2538. 2539. 2540. 2541. 2542. 2543. 2544. 2545. 2546. 2547. 2548. 2549. 2550. 2551. 2552. 2553. 2554. 2555. 2556. 2557. 2558. 2559. 2560. 2561. 2562. 2563. 2564. 2565. 2566. 2567. 2568. 2569. 2570. 2571. 2572. 2573. 2574. 2575. 2576. 2577. 2578. 2579. 2580. 2581. 2582. 2583. 2584. 2585. 2586. 2587. 2588. 2589. 2590. 2591. 2592. 2593. 2594. 2595. 2596. 2597. 2598. 2599. 2600. 2601. 2602. 2603

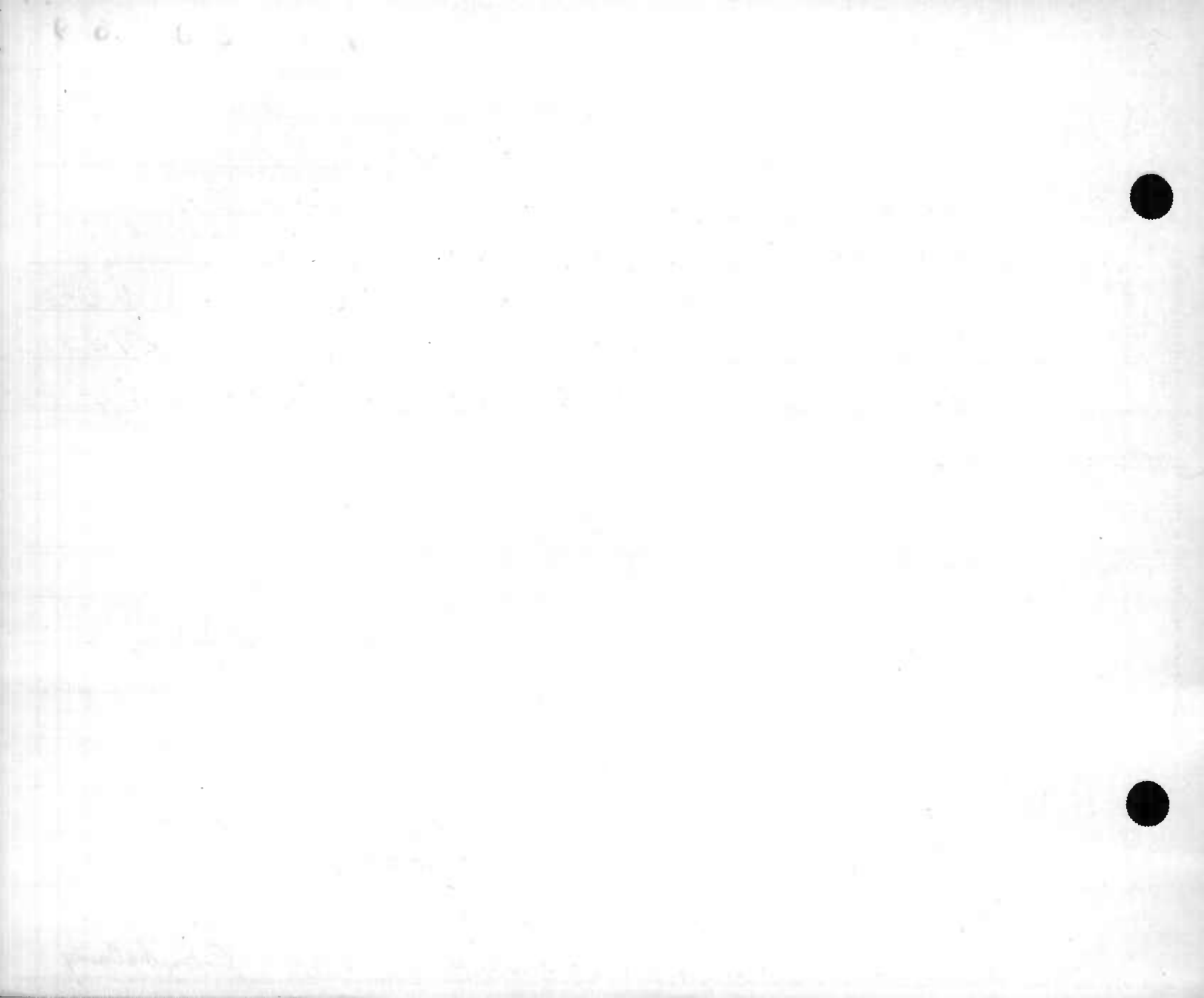
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## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  |  |  |  |                                   |   |   |  |
|--|--|---|--|--|--|--|-----------------------------------|---|---|--|
| 1. FOR<br>STATE<br>REGISTRAR   |  | 7 9 3 0 3 6 9<br>REG. NO.   |  |  |  |  |                                   |   |   |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>John F MARINE</b>   |  |   |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>Dec 12 79</b>            |  |                                   | 2b. HOUR<br><b>9:05</b> M   |   |  |
| 3 SEX<br><b>MALE</b>   |  | 4 RACE<br><b>BLACK</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>11 21 88</b>  |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br><b>91</b> YRS                                      |                                   | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN  |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MARYLAND</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTO CITY</b> MD.                         |                                   |   |   |  |
| 10 CITY OR TOWN OF DEATH<br><b>BALTO. CITY</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>LUTHERAN Hosp. of Md.</b> |  |  |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Ret.</b>      |                                   | 12b. KIND OF BUSINESS OR INDUSTRY   |   |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>Md.</b>  |  |   |  |  | 13b. COUNTY<br><b>BALTO</b>  |  | 13c. CITY OR TOWN<br><b>BALTO</b> |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>JOSIAH HENRY MARINE</b>  |  |   |  |  | 15 MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>CARRIE KIRK</b> |  |                                   |   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>178-18-2998</b>  |  | 17 INFORMANT<br>ADDRESS<br><b>Audrey Wardlaw 401 N. Edgewood</b>   |  |  |                                   |   |   |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>congestive heart failure</b><br>4292<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Senility</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>ASCVD</b><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                              |  |   |  |  |  |  |                                   |   |   |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |   |  |  |  |  |                                   |   |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |  |                                   |   |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |  |                                   |   |   |  |
| 22a. I certify that (1) (this hospital) attended the deceased from <b>11/24</b> , 19 <b>79</b> , to <b>12/12</b> , 19 <b>79</b> , that (1) (we) last saw the deceased alive on <b>12/12</b> , 19 <b>79</b> , and that in (1) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) did (did not) view the body after death. |  |   |  |  |  |  |                                   |   |   |  |
| 22b. SIGNATURE<br><b>Kwang N. Kim MD.</b>  |  |   |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>       |  |  |                                   | 22c. DATE SIGNED<br><b>12/12/79</b>   |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>KWANG NAM KIM MD</b>   |  |   |  | 22e. ADDRESS<br><b>730 ASHBURTON Ave</b>   |  |  |                                   |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>BURIAL</b>  |  | 23b. DATE<br><b>12-18-79</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>ARBUTUS MEM.</b>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore, Md</b>                   |                                   |   |   |  |
| 24 FUNERAL DIRECTOR<br>NAME<br><b>ISAIAH L BROWN &amp; SON P.O.</b>  |  |   |  | ADDRESS<br><b>1913 W BALTO</b>   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>DEC 17 1979</b>                                  |                                   | 25b. REGISTRAR'S SIGNATURE<br><b>P. H. H. H.</b>  |   |  |



**IMPORTANT:** If Item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |   |        |  |                                 |   |         |  |                |
|--|--|---|--------|--|---------------------------------|---|---------|--|----------------|
| 1 DECEASED NAME<br>(TYPE OR PRINT)   |  | FIRST   | MIDDLE | LAST   | 26 DATE OF DEATH MONTH DAY YEAR |   | 28 HOUR |  |                |
| CHARLES  |  |   |        | MARINO   | DECEMBER 19 1979                |   | 3PM     |  |                |
| 3 SEX  |  | 4 RACE  |        | 5 DATE OF BIRTH  |                                 | 6 AGE (IN YEARS LAST BIRTHDAY)  |         | # UNDER 1 YEAR   | # UNDER 24 HRS |
| M  |  | Caucasian   |        | MONTH DAY YEAR<br>8 16 05  |                                 | 74 YRS.   |         | MONTHS DAYS  | HOURS MIN      |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  | 7b CITIZEN OF WHAT COUNTRY?   |        | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                 | 9 BALTIMORE CITY OR COUNTY OF DEATH   |         |  | MD             |
| Italy  |  | USA   |        |  |                                 | BALTIMORE CITY  |         |  |                |
| 10 CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |        |  |                                 | 12a USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)                     |         | 12b KIND OF BUSINESS OR INDUSTRY   |                |
| Baltimore Md   |  | JOHNS HOPKINS HOSPITAL  |        |  |                                 | Contractor  |         |  |                |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  | 13a STATE   |        | 13b COUNTY   |                                 | 13c CITY OR TOWN  |         | 13d INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                       |                |
| Md   |  |   |        |  |                                 | Baltimore   |         |  |                |
| 14 FATHER'S NAME FIRST MIDDLE LAST   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST  |        |  |                                 |   |         |  |                |
| Joseph   |  | Marino  |        | Mary   |                                 |   |         |  |                |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)  |  | 16b SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)  |        | 17 INFORMANT ADDRESS   |                                 |   |         |  |                |
|  |  | 217-16-0640   |        | Mrs Lena Marino - 3226 Eastern Ave   |                                 |   |         |  |                |
| 11 CAUSE OF DEATH (Enter only one cause per line for 1a), 1b), and 1c).<br>PART I: DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Cardiorespiratory arrest<br>1629<br>Conditions, if any, which gave rise to immediate cause 1a), stating the underlying cause last<br>DOE TO, OR AS A CONSEQUENCE OF<br>1b) Lung cancer<br>DOE TO, OR AS A CONSEQUENCE OF<br>1c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>5 min.<br>2 yrs. |  |   |        |  |                                 |   |         |  |                |
| PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a)   |  |   |        |  |                                 |   |         |  |                |
| 19a DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |        |  |                                 | 20a AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |         | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |        | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |                                 |   |         |  |                |
| 21d INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                     |        | 21f LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |                                 |   |         |  |                |
| 22a I certify that (I) (this hospital) attended the deceased from 12/19 1979 to 12/19 1979, that (I) (we) lost to 12/19 1979, and that in my(our) opinion death occurred on the date and hour-and from the causes stated above (I) (we) did (did not) view the body after death.   |  |   |        |  |                                 |   |         |  |                |
| 22b SIGNATURE<br>Theodore K. Amcott MD   |  |   |        | 22c DATE SIGNED<br>12/19/79  |                                 |   |         |  |                |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT)   |  |   |        | 22e ADDRESS  |                                 |   |         |  |                |
| Theodore K. Amcott   |  |   |        | Johns Hopkins Hospital   |                                 |   |         |  |                |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY)   |  | 23b DATE  |        | 23c NAME OF CEMETERY OR CREMATORY  |                                 | 23d LOCATION<br>CITY OR TOWN COUNTY STATE   |         |  |                |
| Burial   |  | 12/22/79  |        | Sacred Heart   |                                 | Baltimore Md  |         |  |                |
| 24 FUNERAL DIRECTOR NAME   |  |   |        | 25a DATE REC'D. BY REGISTRAR   |                                 | 25b REGISTRAR'S SIGNATURE   |         |  |                |
| Zannino Fun. Home 263 S COOKLICK ST  |  |   |        | DEC 21 1979  |                                 | Ruthy McCreedy  |         |  |                |



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## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  |  |  |  |  |                            |  |  |  |       |  |      |  |          |  |  |  |
|--|--|--|--|--|--|--|--|----------------------------|--|--|--|-------|--|------|--|----------|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  | FIRST  |  | MIDDLE   |  | LAST   |  | 2a. DATE OF DEATH          |  | MONTH  |  | DAY   |  | YEAR |  | 2b. HOUR |  |  |  |
| FLORENCE   |  | M.   |  | MARKLE   |  |  |  | 12-21-79                   |  |  |  |       |  |      |  | 3:10 PM  |  |  |  |
| 3. SEX   |  | 4. RACE  |  | 5. DATE OF BIRTH   |  | 6. AGE (IN YEARS LAST BIRTHDAY)  |  | IF UNDER 1 YEAR            |  | IF UNDER 24 HRS  |  |       |  |      |  |          |  |  |  |
| FEMALE   |  | WHITE  |  | 12-25-89   |  | 89   |  | MONTHS                     |  | DAYS   |  | HOURS |  | MIN  |  |          |  |  |  |
| 7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH   |  |                            |  |  |  |       |  |      |  |          |  |  |  |
| MARYLAND   |  | USA  |  |  |  | BALTO. CITY  |  |                            |  |  |  |       |  |      |  |          |  |  |  |
| 10. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)                                     |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |                            |  |  |  |       |  |      |  |          |  |  |  |
| BALTO. CITY  |  | Lutheran Hospital of Maryland  |  | BENDIX CORP  |  | Roti   |  |                            |  |  |  |       |  |      |  |          |  |  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  | 13b. COUNTY  |  | 13c. CITY OR TOWN  |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS        |  |  |  |       |  |      |  |          |  |  |  |
| Maryland   |  | Baltimore  |  | Towson   |  |  |  | 77 Cedar Ave., Towson, Md. |  |  |  |       |  |      |  |          |  |  |  |
| 14. FATHER'S NAME  |  | 15. MOTHER'S MAIDEN NAME   |  |  |  |  |  |                            |  |  |  |       |  |      |  |          |  |  |  |
| Harry  |  | Kate   |  |  |  |  |  |                            |  |  |  |       |  |      |  |          |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)  |  | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT  |  | Reading, P.A.  |  | 19604                      |  |  |  |       |  |      |  |          |  |  |  |
| no   |  | 066-16-0987A   |  | Mr. Harold E. Guldin, 1238 Linden St.  |  |  |  |                            |  |  |  |       |  |      |  |          |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Coronary heart failure</u>   |  |  |  |  |  |  |  |                            |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH               |  |       |  |      |  |          |  |  |  |
| 4148   |  |  |  |  |  |  |  |                            |  | DUE TO, OR AS A CONSEQUENCE OF                             |  |       |  |      |  |          |  |  |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last  |  |  |  |  |  |  |  |                            |  | (b) <u>Previous (old) inf. M.I. &amp; antec. led. M.I.</u> |  |       |  |      |  |          |  |  |  |
|  |  |  |  |  |  |  |  |                            |  | DUE TO, OR AS A CONSEQUENCE OF                             |  |       |  |      |  |          |  |  |  |
|  |  |  |  |  |  |  |  |                            |  | (c)  |  |       |  |      |  |          |  |  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <u>Senile dementia @ Acute ulcer (sacrum)</u>   |  |  |  |  |  |  |  |                            |  |  |  |       |  |      |  |          |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?                               |  |                            |  |  |  |       |  |      |  |          |  |  |  |
| 11-27-79   |  | Debridement of necrotic ulcer  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | YES <input type="checkbox"/> NO <input type="checkbox"/>                                     |  |                            |  |  |  |       |  |      |  |          |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)   |  |  |  |                            |  |  |  |       |  |      |  |          |  |  |  |
|  |  | HOUR A.M. MONTH DAY YEAR   |  |  |  |  |  |                            |  |  |  |       |  |      |  |          |  |  |  |
|  |  | P.M. 19  |  |  |  |  |  |                            |  |  |  |       |  |      |  |          |  |  |  |
| 21d. INJURY OCCURRED   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION  |  |  |  |                            |  |  |  |       |  |      |  |          |  |  |  |
| WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |  |  | STREET   |  | CITY OR TOWN   |  | COUNTY                     |  | STATE  |  |       |  |      |  |          |  |  |  |
|  |  |  |  |  |  |  |  |                            |  |  |  |       |  |      |  |          |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 11-13-79 to 12-21-79, that (I) (we) lost saw the deceased alive on 12-21-79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |  |  |                            |  |  |  |       |  |      |  |          |  |  |  |
| 22b. SIGNATURE   |  | DEGREE   |  | 22c. DATE SIGNED   |  |  |  |                            |  |  |  |       |  |      |  |          |  |  |  |
| Bruce A. Blumenthal MD   |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 12/21/79   |  |  |  |                            |  |  |  |       |  |      |  |          |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  | 22e. ADDRESS   |  |  |  |  |  |                            |  |  |  |       |  |      |  |          |  |  |  |
| B. Blumenthal MD   |  | Lutheran Hospital BALTO, MD  |  |  |  |  |  |                            |  |  |  |       |  |      |  |          |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION  |  |                            |  |  |  |       |  |      |  |          |  |  |  |
| Cremation  |  | 12/26/79   |  | Westview Cemetery  |  | Catonsville, Baltimore Md.   |  |                            |  |  |  |       |  |      |  |          |  |  |  |
| 24. FUNERAL DIRECTOR   |  | 25a. DATE REC'D. BY REGISTRAR  |  | 25b. REGISTRAR'S SIGNATURE   |  |  |  |                            |  |  |  |       |  |      |  |          |  |  |  |
| 1630 Edmondson Ave., Catonsville, Md.  |  | 26 DEC 26 1979   |  | Fitzgerald   |  |  |  |                            |  |  |  |       |  |      |  |          |  |  |  |
| Witzke Funeral Home of Catonsville, P.A. 21228   |  |  |  |  |  |  |  |                            |  |  |  |       |  |      |  |          |  |  |  |

11. 1. 1900

Received of Mr. J. H. Smith  
the sum of \$100.00

for rent of land

W. H. Smith



DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 30372

|  |                         |   |   |  |  |   |   |  |
|--|-------------------------|---|---|--|--|---|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Natalie Florence Maroney</b>   |                         |   | 2a. DATE KNOWN OF DEATH<br>ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR<br><b>12 30 19 79</b> |  |  | 2b. HOUR<br>M<br><b>10:02 AM</b>  |   |  |
| 3. SEX<br><b>Female</b>  | 4. RACE<br><b>White</b> | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>10 13 79</b> | 6. AGE (IN YEARS)<br>(LAST BIRTHDAY)<br>MONTHS DAYS<br><b>2 16</b>  | IF UNDER 1 YR.<br>MONTHS DAYS<br><b>2 16</b> | IF UNDER 24 HRS.<br>HOURS MIN.<br><b>10 02</b> | 2c. DATE PRONOUNCED DEAD<br>MONTH DAY YEAR<br><b>12 30 19 79</b>  |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>   |                         |   | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   |  |
| 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City,</b> MD.   |                         |   | 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   |  |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Baltimore City Hospital</b>                |   |  |
| 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |                         |   | 12b. KIND OF BUSINESS OR INDUSTRY   |  |  |   |   |  |
| 13a. STATE<br><b>Maryland</b>  |                         |   | 13b. COUNTY<br><b>Baltimore</b>   |  |  | 13c. CITY OR TOWN<br><b>Dundalk</b>   |   |  |
| 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                         |   | 13e. STREET ADDRESS<br><b>1968 Guyway</b>   |  |  |   |   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Michael J. Maroney</b>  |                         |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Brenda F. Cutler</b>                                      |  |  |   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>No</b>   |                         |   | 16b. SOCIAL SECURITY NO.  |  |  | 17. INFORMANT ADDRESS<br><b>1968 Guyway Balto. MD 21222</b>   |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1 DEATH WAS CAUSED BY:<br><b>7980</b> IMMEDIATE CAUSE (a) <u>Sudden infant death syndrome</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____   |                         |   |   |  |  |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |                         |   |   |  |  |   |   |  |
| 19a. DATE OF OPERATION   |                         |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |  |  |   | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |                         |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK  |                         |   | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)   |  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |  |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . |                         |   |   |  |  |   |   |  |
| ACTUAL SIGNATURE <u>Virginia L. Dolan</u>  |                         |   | TITLE (SPECIFY)<br><b>Assistant</b>   |  |  | DATE SIGNED <b>12/31/79</b>   |   |  |
| EXAMINER'S NAME (TYPE OR PRINT)<br><b>Virginia L. Dolan, M.D.</b>  |                         |   | ADDRESS<br><b>111 Penn Street</b>   |  |  |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |                         |   | 23b. DATE<br><b>1/2/80</b>  |  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Holly Hill Mem.</b>  |   |  |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>White Marsh, Balto. MD</b>  |                         |   | 25a. DATE REC'D. BY REGISTRAR<br><b>JAN 3 1980</b>  |  |  | 25b. REGISTRAR'S SIGNATURE<br><i>History/History</i>  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Duda-Ruck, Inc. 7922 Wise Avenue, Dundalk, MD 21222</b>   |                         |   |   |  |  |   |   |  |

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

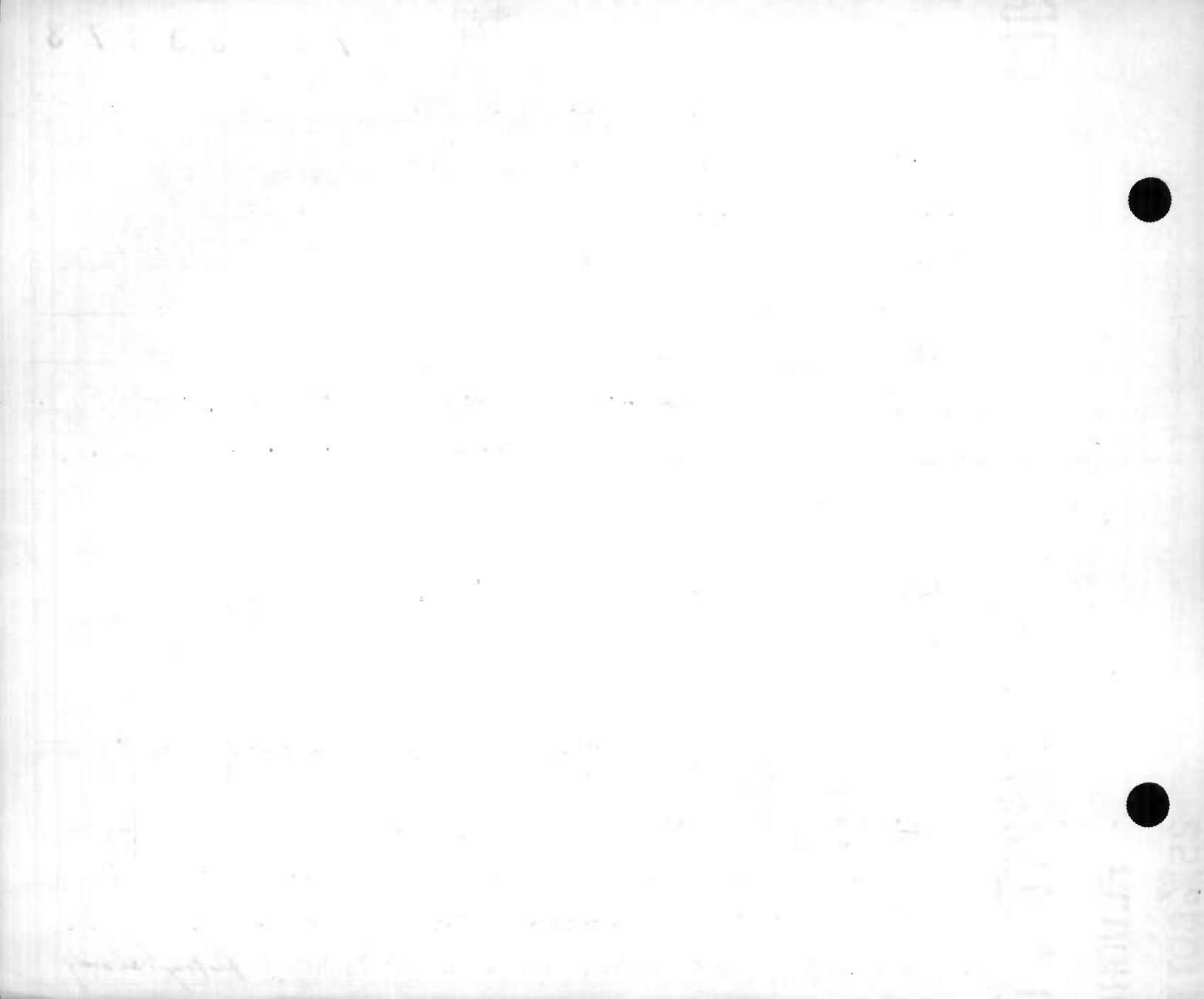
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 3 and 4 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of this.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  |  |   |  |      |     |   | 79 30374 |           |   |  |                    |              |  |
|--|--|--|--|--|---|--|------|-----|---|----------|-----------|---|--|--------------------|--------------|--|
| 1. FOR STATE REGISTRAR   |  |  | REG. NO.   |  |   |  |      |     |   |          |           |   |  |                    |              |  |
| 1. DECEASED NAME (TYPE OR PRINT)   |  |  | 2a. DATE OF DEATH  |  |   | MONTH  |      | DAY |   | YEAR     |           | 2b. HOUR  |  |                    |              |  |
| ANDREW W. MARSH  |  |  | DECEMBER   |  | 2 |  | 1979 |     |   |          | 11:47A.M. |   |  |                    |              |  |
| 3. SEX   |  |  | 4. RACE  |  |   | 5. DATE OF BIRTH   |      |     | 6. AGE (IN YEARS LAST BIRTHDAY)                                     |          |           | 7. IF UNDER 1 YEAR  |  | 8. IF UNDER 24 HRS |              |  |
| MALE   |  |  | White  |  |   | 5-21-1896  |      |     | 83 YRS.   |          |           | MONTHS  |  | DAYS               |              |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  |  | 7b. CITIZEN OF WHAT COUNTRY?   |  |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |      |     | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |          |           |   |  |                    |              |  |
| VIRGINIA   |  |  | U.S.A.   |  |   |  |      |     | BALTIMORE CITY MD.  |          |           |   |  |                    |              |  |
| 10. CITY OR TOWN OF DEATH  |  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |      |     | 12b. KIND OF BUSINESS OR INDUSTRY                                   |          |           |   |  |                    |              |  |
| BALTIMORE  |  |  | Church Home Hosp   |  |   | RETIRED  |      |     | FARMER  |          |           |   |  |                    |              |  |
| 13a. STATE   |  |  | 13b. COUNTY  |  |   | 13c. CITY OR TOWN  |      |     | 13d. INSIDE CITY LIMITS?  |          |           | 13e. STREET ADDRESS   |  |                    |              |  |
| VIRGINIA   |  |  | MADISON  |  |   | MADISON  |      |     | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |          |           | RURAL   |  |                    |              |  |
| 14. FATHER'S NAME  |  |  | 15. MOTHER'S MAIDEN NAME   |  |   | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)  |      |     | 16b. SOCIAL SECURITY NO.  |          |           | 17. INFORMANT   |  |                    | ADDRESS      |  |
| William  |  |  | Edith  |  |   | yes  |      |     | 226-24-3020A  |          |           | MARGARET DORMAN   |  |                    | BALTIMORE MD |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |  |  |  |  |   |  |      |     |   |          |           | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                |  |                    |              |  |
| PART I. DEATH WAS CAUSED BY: PNEUMONIA   |  |  |  |  |   |  |      |     |   |          |           |   |  |                    |              |  |
| IMMEDIATE CAUSE (a)  |  |  |  |  |   |  |      |     |   |          |           |   |  |                    |              |  |
| DUE TO, OR AS A CONSEQUENCE OF   |  |  |  |  |   |  |      |     |   |          |           |   |  |                    |              |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.   |  |  |  |  |   |  |      |     |   |          |           |   |  |                    |              |  |
| DUE TO, OR AS A CONSEQUENCE OF   |  |  |  |  |   |  |      |     |   |          |           |   |  |                    |              |  |
| (c)  |  |  |  |  |   |  |      |     |   |          |           |   |  |                    |              |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |  |  |  |   |  |      |     |   |          |           |   |  |                    |              |  |
| OLD CEREBROVASCULAR ACCIDENT, DEHYDRATION  |  |  |  |  |   |  |      |     |   |          |           |   |  |                    |              |  |
| CEREBROVASCULAR  |  |  |  |  |   |  |      |     |   |          |           |   |  |                    |              |  |
| 19a. DATE OF OPERATION   |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   | 20a. AUTOPSY?  |      |     | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?      |          |           |   |  |                    |              |  |
|  |  |  |  |  |   | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |      |     | YES <input type="checkbox"/> NO <input type="checkbox"/>            |          |           |   |  |                    |              |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  | 21b. TIME OF INJURY  |  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |      |     |   |          |           |   |  |                    |              |  |
|  |  |  | HOUR A.M. MONTH DAY YEAR   |  |   |  |      |     |   |          |           |   |  |                    |              |  |
|  |  |  | P.M. 19  |  |   |  |      |     |   |          |           |   |  |                    |              |  |
| 21d. INJURY OCCURRED   |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  |   | 21f. LOCATION  |      |     |   |          |           |   |  |                    |              |  |
| WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |  |  |  |   | STREET   |      |     | CITY OR TOWN COUNTY STATE   |          |           |   |  |                    |              |  |
| 22a. I certify that (I) (this hospital) attended the deceased from NOVEMBER 30, 1979, to DECEMBER 2, 1979, that (I) (we) last saw the deceased alive on DECEMBER 2, 1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. |  |  |  |  |   |  |      |     |   |          |           |   |  |                    |              |  |
| 22b. SIGNATURE   |  |  |  |  |   |  |      |     |   |          |           | DEGREE  |  | 22c. DATE SIGNED   |              |  |
| A.F. MOUR  |  |  |  |  |   |  |      |     |   |          |           | MD  |  | 12-2-79            |              |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  |  |  |  |   |  |      |     |   |          |           | 22e. ADDRESS  |  |                    |              |  |
| A.F. MOUR M.D.   |  |  |  |  |   |  |      |     |   |          |           | CHURCH HOSPITAL, 100 N. BROADWAY, BALTIMORE, MARYLAND 21231 |  |                    |              |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |  |  | 23b. DATE  |  |   | 23c. NAME OF CEMETERY OR CREMATORY   |      |     | 23d. LOCATION   |          |           | COUNTY  |  | STATE              |              |  |
| BURIAL   |  |  | 12-5-79  |  |   | Cedar Hill Cem   |      |     | MADISON   |          |           |   |  | VA.                |              |  |
| 24. FUNERAL DIRECTOR   |  |  |  |  |   | 25a. DATE REC'D. BY REGISTRAR  |      |     |   |          |           | 25b. REGISTRAR'S SIGNATURE                                  |  |                    |              |  |
| NAME   |  |  |  |  |   | ADDRESS  |      |     |   |          |           |   |  |                    |              |  |
| CLORE FUNERAL HOME   |  |  |  |  |   | CUPEPER, VA.   |      |     |   |          |           | DEC 5 1979  |  | J. H. McCreedy     |              |  |

BP

DHMH-16 20M  
(VRA 15, 4) 7/78

1124035

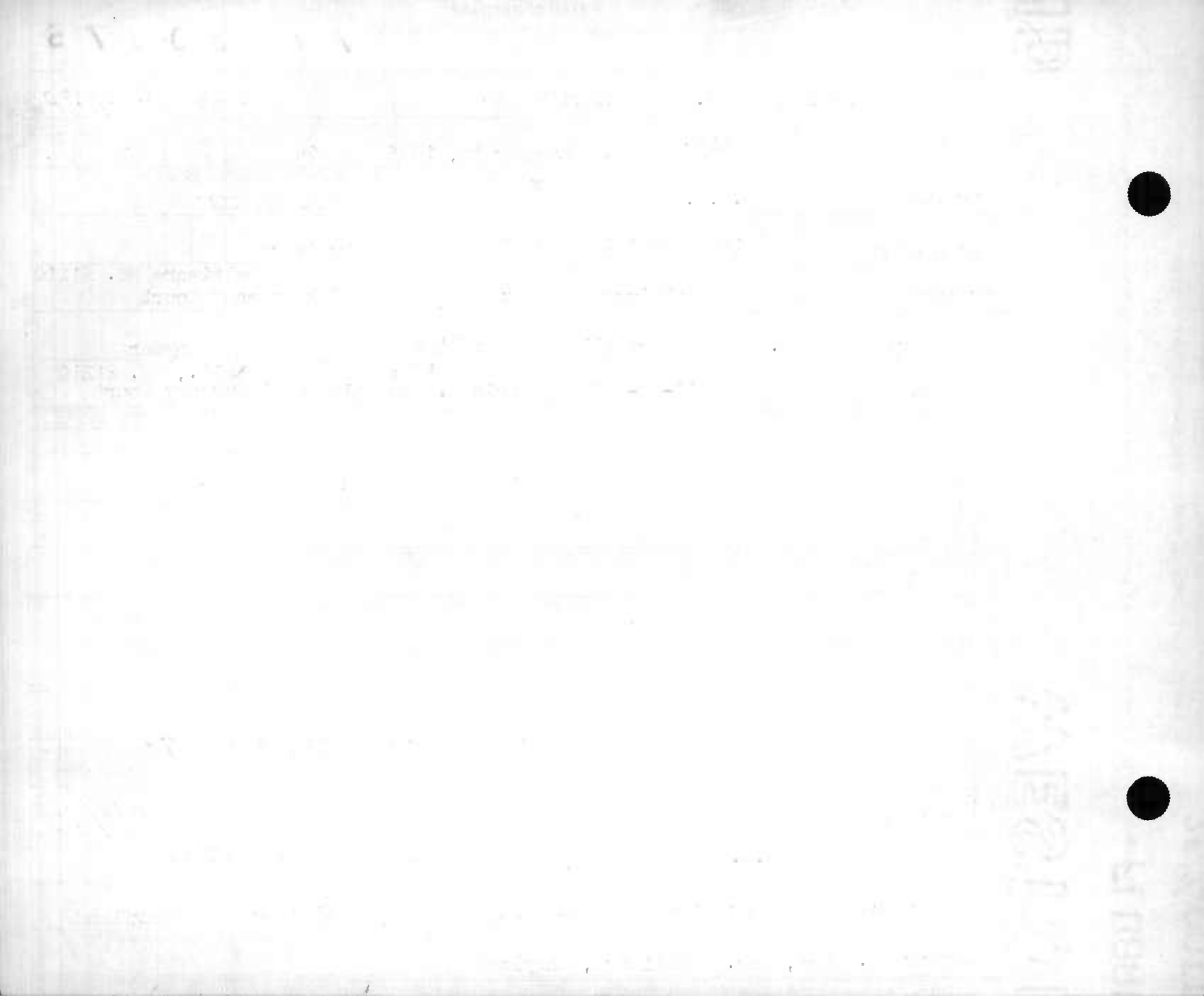
AT-3-1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  |   |  |   |  |                     |  | 7 9 3 0 3 7 5   |     |  |           |  |  |
|---|--|--|--|---|--|---|--|---------------------|--|---|-----|--|-----------|--|--|
| 1. FOR STATE REGISTRAR  |  | REG. NO.   |  |   |  |   |  |                     |  |   |     |  |           |  |  |
| 1. DECEASED NAME (TYPE OR PRINT)  |  | FIRST  |  | MIDDLE  |  | LAST  |  | 2a. DATE OF DEATH   |  | MONTH   | DAY | YEAR   | 2b. HOUR  |  |  |
| CHARLES   |  | H.   |  | MARSHALL  |  |   |  | 12-9-79             |  |   |     |  | 4:50 P.M. |  |  |
| 3. SEX  |  | 4. RACE  |  | 5. DATE OF BIRTH  |  | 6. AGE (IN YEARS LAST BIRTHDAY)                                     |  | 7. IF UNDER 1 YEAR  |  | 8. IF UNDER 24 HRS  |     |  |           |  |  |
| Male  |  | White  |  | November 16, 1905   |  | 74 YRS  |  | MONTHS              |  | DAYS  |     | HOURS MIN.   |           |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |  |                     |  |   |     |  |           |  |  |
| Maryland  |  | U.S.A.   |  |   |  | BALTIMORE CITY  |  |                     |  |   |     | MD.  |           |  |  |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)   |  | 12b. KIND OF BUSINESS OR INDUSTRY                                   |  |                     |  |   |     |  |           |  |  |
| BALTIMORE   |  | Union Memorial Hospital  |  | Architect   |  |   |  |                     |  |   |     |  |           |  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  | 13a. COUNTY  |  | 13b. CITY OR TOWN   |  | 13c. INSIDE CITY LIMITS?  |  | 13d. STREET ADDRESS |  |   |     |  |           |  |  |
| Maryland  |  | Baltimore  |  | Baltimore   |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | Baltimore Md. 21210 |  |   |     |  |           |  |  |
| 14. FATHER'S NAME   |  | 15. MOTHER'S MAIDEN NAME   |  |   |  |   |  |                     |  |   |     |  |           |  |  |
| FIRST MIDDLE LAST   |  | FIRST MIDDLE LAST  |  |   |  |   |  |                     |  |   |     |  |           |  |  |
| Henry S. Marshall   |  | Pauline Snyder   |  |   |  |   |  |                     |  |   |     |  |           |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)   |  | 16b. SOCIAL SECURITY NO  |  | 17. INFORMANT   |  | ADDRESS   |  |                     |  |   |     |  |           |  |  |
| No  |  | 212-12-4818  |  | Wife: Marie V. Marshall   |  | Balt., Md. 21210  |  | 4203 Tuscany Court  |  |   |     |  |           |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cardiopulmonary arrest</u><br>4140<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Coronary Heart Disease</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):<br><u>Possible pneumonia</u> |  |  |  |   |  |   |  |                     |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                        |     |  |           |  |  |
| 19a. DATE OF OPERATION  |  |  |  |   |  |   |  |                     |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                    |     | 20a. AUTOPSY?  |           | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |  |
|   |  |  |  |   |  |   |  |                     |  |   |     | YES <input type="checkbox"/> NO <input type="checkbox"/>                       |           | YES <input type="checkbox"/> NO <input type="checkbox"/>       |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  |  |   |  |   |  |                     |  | 21b. TIME OF INJURY   |     | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |           |  |  |
|   |  |  |  |   |  |   |  |                     |  | HOUR A.M. MONTH DAY YEAR  |     |  |           |  |  |
|   |  |  |  |   |  |   |  |                     |  | P.M. 19   |     |  |           |  |  |
| 21d. INJURY OCCURRED  |  |  |  |   |  |   |  |                     |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |     | 21f. LOCATION  |           |  |  |
| WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |  |  |   |  |   |  |                     |  |   |     | STREET   |           | CITY OR TOWN COUNTY STATE                                      |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>12/8</u> , 19 <u>79</u> , to <u>12/9</u> , 19 <u>79</u> , that (I) (we) lost saw the deceased alive on <u>12-9</u> , 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.  |  |  |  |   |  |   |  |                     |  |   |     |  |           |  |  |
| 22b. SIGNATURE  |  |  |  |   |  |   |  |                     |  | DEGREE  |     | 22c. DATE SIGNED   |           |  |  |
| <u>Yael Yobel</u>   |  |  |  |   |  |   |  |                     |  | M.D.  |     | 10/9/79  |           |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  |  |  |   |  |   |  |                     |  | 22e. ADDRESS  |     |  |           |  |  |
| Yael Yobel M.D.   |  |  |  |   |  |   |  |                     |  | UNION MEMORIAL HOSPITAL   |     |  |           |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   |  |  |  |   |  |   |  |                     |  | 23b. DATE   |     | 23c. NAME OF CEMETERY OR CREMATORY   |           | 23d. LOCATION  |  |
| Burial  |  |  |  |   |  |   |  |                     |  | Dec 13 1979   |     | Loudon Park  |           | Baltimore  |  |
|   |  |  |  |   |  |   |  |                     |  |   |     |  |           | COUNTY STATE   |  |
|   |  |  |  |   |  |   |  |                     |  |   |     |  |           | Maryland   |  |
| 24. FUNERAL DIRECTOR  |  |  |  |   |  |   |  |                     |  | 25a. DATE REC'D. BY REGISTRAR                                       |     | 25b. REGISTRAR'S SIGNATURE   |           |  |  |
| NAME Leonard J. Ruck, Inc.  |  |  |  |   |  |   |  |                     |  | ADDRESS Baltimore, Maryland   |     | DEC 11 1979  |           |  |  |





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  |  |  |  |  |   |  |                                   |  |
|---|--|--|--|--|--|--|--|---|--|-----------------------------------|--|
| 1. FOR STATE REGISTRAR  |  | 7 9 3 0 3 7 6<br>REG. NO.  |  |  |  |  |  |   |  |                                   |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |  | FIRST  |  | MIDDLE   |  | LAST   |  | 2a. DATE OF DEATH MONTH DAY YEAR  |  | 2b. HOUR                          |  |
| William Arringdale  |  | MARSHALL, III  |  | December 17, 1979  |  | 3 P.M.   |  |   |  |                                   |  |
| 3. SEX  |  | 4. RACE  |  | 5. DATE OF BIRTH MONTH DAY YEAR  |  | 6. AGE (IN YEARS LAST BIRTHDAY)  |  | IF UNDER 1 YEAR MONTHS DAYS   |  | IF UNDER 24 HRS HOURS MIN.        |  |
| Male  |  | White  |  | Aug. 7, 1906   |  | 73   |  |   |  |                                   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                                   |  |   |  |                                   |  |
| Ruxton, Balto Co. Md.   |  | USA  |  |  |  | Baltimore CITY MD.   |  |   |  |                                   |  |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |  |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)   |  | 12b. KIND OF BUSINESS OR INDUSTRY |  |
| Baltimore   |  | Residence: 5704 Kenmore Road   |  |  |  |  |  | Civil Engineer  |  |                                   |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  | 13a. STATE   |  | 13b. COUNTY  |  | 13c. CITY OR TOWN  |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |  | 13e. STREET ADDRESS               |  |
| Md.   |  |  |  | Baltimore  |  |  |  | 5704 Kenmore Road   |  |                                   |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST   |  |  |  |  |  |   |  |                                   |  |
| Charles Morgan Marshall   |  | Hemalene Dillinger   |  |  |  |  |  |   |  |                                   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)   |  | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT Sister: ADDRESS  |  |  |  |   |  |                                   |  |
| Yes   |  | WWII   |  | Esther D. Marshall, 5704 Kenmore Rd., City   |  |  |  |   |  |                                   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cardiopulmonary arrest</u><br>4292<br>DUE TO, OR AS A CONSEQUENCE OF (b) <u>A. S.C.V.D.</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF (c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>Sudden</u><br><u>? years.</u> |  |  |  |  |  |  |  |   |  |                                   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |  |  |  |  |  |  |   |  |                                   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |                                   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |  |  |   |  |                                   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |  |  |   |  |                                   |  |
| 22a. I certify that (I) <u>Edwin B. Jarrett</u> attended the deceased from <u>5/31/47</u> , 19____, to <u>12/17/79</u> , 19____, that (I) <u>did not</u> lose sight of the deceased alive on <u>12/14/79</u> , 19____, and that in (my) <u>own</u> opinion death occurred on the date and hour and from the causes stated above, (I) <u>did not</u> view the body after death.  |  |  |  |  |  |  |  |   |  |                                   |  |
| 22b. SIGNATURE <u>Edwin B. Jarrett M.D.</u>   |  | DEGREE   |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>               |  |  |  | 22c. DATE SIGNED <u>12/19/79</u>  |  |                                   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Edwin B. Jarrett, M.D.</u>   |  | 22e. ADDRESS <u>11 East Chase St., Baltimore, Maryland.</u>  |  |  |  |  |  |   |  |                                   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Entombment</u>   |  | 23b. DATE <u>Dec. 20, 1979</u>   |  | 23c. NAME OF CEMETERY OR CREMATORY <u>Green Mount</u>  |  | 23d. LOCATION CITY OR TOWN <u>Baltimore</u> COUNTY <u>Md.</u> STATE    |  | 23e. DATE REC'D. BY REGISTRAR <u>DEC 24 1979</u>  |  |                                   |  |
| 24. FUNERAL DIRECTOR NAME <u>STEWART &amp; MOWEN CO.</u>  |  | ADDRESS <u>108 W. North Av., City 21201</u>  |  | 25a. DATE REC'D. BY REGISTRAR <u>DEC 24 1979</u>   |  | 25b. REGISTRAR'S SIGNATURE <u>Patricia McCready</u>                    |  |   |  |                                   |  |



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

1503 BP  
DHMM - 17  
(VR A15 ME (5))  
30M 7/73

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |                         |  |   |   |   |   |  |   |  | REG. NO. 30377   |  |
|--|-------------------------|--|---|---|---|---|--|---|--|--|--|
| 1. FOR STATE REGISTRAR   |                         | 2a. DECEASED NAME<br>(TYPE OR PRINT) <b>Sam</b>  |   |   |   | MIDDLE <b>Martin, Jr.</b>   |  |   |  | 2b. DATE KNOWN OF DEATH<br>ESTIMATED <input checked="" type="checkbox"/> MONTH <b>12</b> DAY <b>7</b> YEAR <b>1979</b> |  |
| 3. SEX<br><b>Male</b>  | 4. RACE<br><b>Black</b> | 5. DATE OF BIRTH<br>MONTH <b>8</b> DAY <b>4</b> YEAR <b>1923</b>   | 6. AGE (IN YEARS)<br>LAST BIRTHDAY <b>56</b> YRS. | IF UNDER 1 YR.<br>MONTHS <b>0</b> DAYS <b>0</b>   | IF UNDER 24 HRS.<br>HOURS <b>0</b> MIN <b>0</b> | 2c. DATE PRONOUNCED DEAD<br>MONTH <b>12</b> DAY <b>7</b> YEAR <b>1979</b>         |  | 2d. HOUR <b>8:46</b> P <b>M</b>   |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MADISON NC</b>   |                         | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City,</b> MD.                |  |   |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |                         | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Lutheran Hospital</b> |   |   |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>CHAUFFEUR</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>TRUCKING</b>                                |  |  |  |
| 13a. STATE<br><b>MD</b>  |                         | 13b. COUNTY<br><b>Baltimore</b>  |   | 13c. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |   | 13e. STREET ADDRESS<br><b>1624 N Smallwood St</b>                                 |  |   |  |  |  |
| 14. FATHER'S NAME<br>FIRST <b>Sam</b> MIDDLE <b>Martin</b> LAST <b>Jr</b>  |                         |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>Agnes</b> MIDDLE <b>L</b> LAST <b>Martin</b>   |   |   |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br><b>no</b>   |                         | 16b. SOCIAL SECURITY NO.<br><b>239-30-3412</b>   |   | 17. INFORMANT<br><b>Lillian Martin</b>  |   | ADDRESS<br><b>1624 N Smallwood St</b>   |  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Arteriosclerotic Cardiovascular Disease</b><br><b>4292</b><br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____   |                         |  |   |   |   |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).  |                         |  |   |   |   |   |  |   |  |  |  |
| 19a. DATE OF OPERATION   |                         | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |   |   |   |   |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |                         | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. <b>19</b>  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |   |   |  |   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |                         | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)  |   | 21f. LOCATION<br>STREET   |   | CITY OR TOWN  |  | COUNTY  |  | STATE  |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |                         |  |   |   |   |   |  |   |  |  |  |
| ACTUAL SIGNATURE<br><b>Virginia L. Dolan</b>   |                         | TITLE (SPECIFY)<br><b>Assistant</b>  |   |   |   | MEDICAL EXAMINER  |  | DATE SIGNED<br><b>12/8/79</b>   |  |  |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT)<br><b>Virginia L. Dolan, M.D.</b>   |                         | ADDRESS<br><b>111 Penn Street</b>  |   |   |   |   |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |                         | 23b. DATE<br><b>12/10/79</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Mt Airy</b>  |   |   |  | 23d. LOCATION<br>CITY OR TOWN <b>Baltimore</b> COUNTY <b>MD</b> STATE               |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>James A. Hargrave</b>   |                         | 24b. ADDRESS<br><b>3825 E. Mount St</b>  |   | 25a. DATE REC'D. BY REGISTRAR<br><b>DEC 10 1979</b>   |   | 25b. REGISTRAR'S SIGNATURE<br><b>Robert Hargrave</b>                              |  |   |  |  |  |



DEC 1 1948

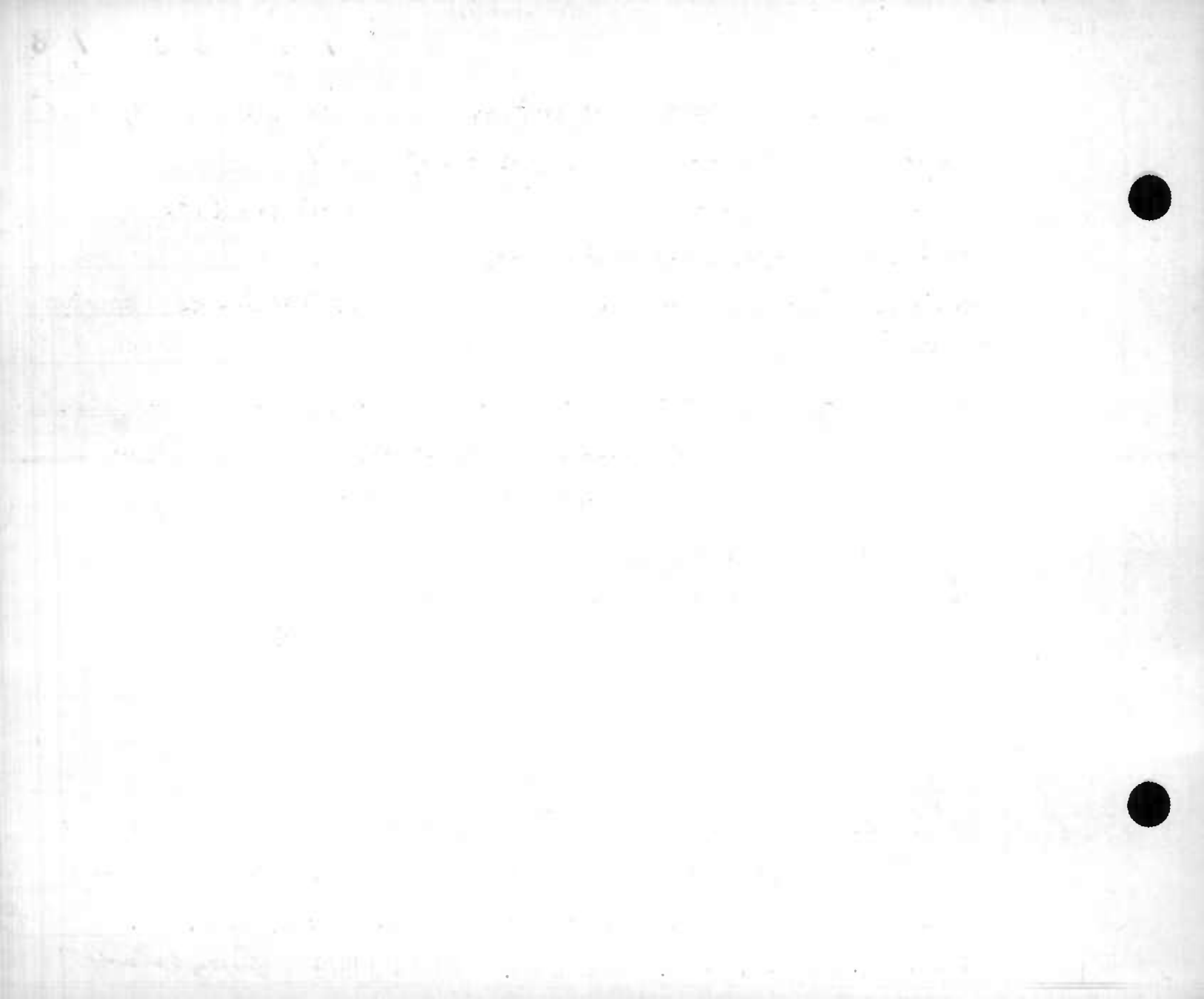
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  |   |   |  |  |  |  |
|---|--|--|--|---|---|--|--|--|--|
| 1- FOR STATE REGISTRAR  |  | 7 9 3 0 3 7 8<br>REG. NO.  |  |   |   |  |  |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>William Fred Martin   |  |  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>December 11, 1979  |  |  | 2b. HOUR<br>10:20 A.M.   |  |
| 3. SEX<br>Male  |  | 4. RACE<br>White   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>9-15-28   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>51 YRS.   |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>New York   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.                           |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Good Samaritan Hospital |  |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>musician         |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Symphony  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE 13b. COUNTY 13c. CITY OR TOWN<br>Maryland Baltimore Lutherville   |  |  |  |   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS<br>3125 Eastridge Rd. Timonium |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Fritz Adolph Martin   |  |  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Erna Weinschenck                               |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>---   |  | 17. INFORMANT ADDRESS<br>Mrs. Emily C. Martin, 2125 Eastridge Rd.   |   |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <u>Acute myocardial Infarction</u><br>410-<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost<br>(b) <u>Arteriosclerotic Heart Disease</u><br>(c) <u>Due to, or as a consequence of</u><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>1/2 hr.</u><br><u>years</u> |  |  |  |   |   |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)<br><u>Cerebral Thrombosis with right hemiparesis</u>  |  |  |  |   |   |  |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |   |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |  |  |   |   |  |  |  |  |
| 22b. SIGNATURE<br>John D. Talbert, M.D.   |  |  |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>        |   |  |  | 22c. DATE SIGNED<br>11 Dec 79  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>John D. Talbert M.D.   |  |  |  | 22e. ADDRESS<br>5601 Loch Raven Blvd Balto, Md 21239  |   |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial   |  | 23b. DATE<br>12/14/79  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Dulaney Valley Cem.   |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Cockeysville, Md.                      |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Martin D. Lawson, 10 W. Padonia Rd.   |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br>DEC 13 1979  |   | 25b. REGISTRAR'S SIGNATURE<br>P. J. H. H. H.   |  |  |  |

BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  |   |  |   |  |   |  | 7 9 3 0 3 7 9<br>REG. NO.  |   |  |  |
|---|--|--|--|---|--|---|--|---|--|--|---|--|--|
| 1. FOR<br>STATE<br>REGISTRAR  |  | 1. DECEASED NAME<br>(TYPE OR PRINT) <b>IVA S. MASON</b>  |  |   |  |   |  | 2a. DATE OF DEATH<br>MONTH <b>12</b> DAY <b>24</b> YEAR <b>79</b>   |  |  | 2b. HOUR<br><b>M</b>                          |  |  |
| 3. SEX<br><b>FEMALE</b>   |  | 4. RACE<br><b>BLACK</b>  |  | 5. DATE OF BIRTH<br>MONTH <b>12</b> DAY <b>3</b> YEAR <b>11</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>68</b> YRS.   |  |   | IF UNDER 1 YEAR<br>MONTHS <b></b> DAYS <b></b> |  | IF UNDER 24 HRS.<br>HOURS <b></b> MIN <b></b> |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Virginia</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.                               |  |   |  |  |   |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>HOUSE IN PINES</b> |  |   |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY             |  |  |
| 13a. STATE<br><b>Maryland</b>   |  | 13b. COUNTY  |  | 13c. CITY OR TOWN<br><b>Baltimore</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>2029 Lewellyn Ave.</b>  |  |  |   |  |  |
| 14. FATHER'S NAME<br>FIRST <b>ALEX</b> MIDDLE <b></b> LAST <b>STOKES</b>  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>ROSA</b> MIDDLE <b></b> LAST <b>ARVIN</b>   |  |   |  |   |  |   |  |  |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>215-22-8077</b>   |  | 17. INFORMANT<br>ADDRESS<br><b>Curtis Stokes 1730 E. Oliver St.</b>   |  |   |  |   |  |  |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1: DEATH WAS CAUSED BY:<br>(IMMEDIATE CAUSE (a)) <b>METASTATIC SQUAMOUS CEL CA OF LUNG</b><br><b>1629</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b></b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b></b>  |  |  |  |   |  |   |  |   |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br><b>18 MO.</b> |   |  |  |
| PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (list)  |  |  |  |   |  |   |  |   |  |  |   |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                       |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |   |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR <b></b> A.M. <b></b> MONTH <b></b> DAY <b></b> YEAR <b>19</b><br>P.M. <b></b>                          |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |   |  |  |   |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET <b></b> CITY OR TOWN <b></b> COUNTY <b></b> STATE <b></b>   |  |   |  |   |  |  |   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>01-02-19-79</b> to <b>12/24-19-79</b> that (I) (two) last<br>saw the deceased alive on <b>12/23-19-79</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) did not view the body after death. |  |  |  |   |  |   |  |   |  |  |   |  |  |
| 22b. SIGNATURE<br><b>Arthur M. Weiss</b>  |  | DEGREE<br><b>M.D.</b>  |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                  |  |   |  | 22c. DATE SIGNED<br><b>12/26/79</b>   |  |  |   |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>ARTHUR M. WEISS</b>   |  | 22e. ADDRESS<br><b>3640 FORDS CANE BAUD 2115</b>   |  |   |  |   |  |   |  |  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>12-29-79</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>BALTIMORE CEM.</b>   |  |   |  | 23d. LOCATION<br>CITY OR TOWN <b>BALTIMORE</b> COUNTY <b></b> STATE <b>MD.</b>  |  |  |   |  |  |
| 24. FUNERAL DIRECTOR<br>NAME <b>Wm. C. March F/H</b> ADDRESS <b>1101 E. North Ave.</b>  |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>DEC 28 1979</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>Ruby McCreedy</b>  |  |   |  |  |   |  |  |





TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, THE EXAMINER SHOULD EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. GIVE PAGE 4 TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES.

TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 48 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP  
DHMH - 17  
(VR A15 AE (5))  
30M 7/73

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |  |                             |  |   |  |  |  |  |  | REG. NO. 30380  |  |                                     |  |
|--|--|-----------------------------|--|---|--|--|--|--|--|---|--|-------------------------------------|--|
| 1. FOR STATE REGISTRAR   |  |                             |  |   |  |  |  |  |  | 2a. DATE KNOWN OF DEATH   |  | 2b. HOUR                            |  |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Douglas W. Matheny JR.  |  |                             |  |   |  |  |  |  |  | 2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR 12 7 19 79 |  | 2b. HOUR 6:45 PM                    |  |
| 3. SEX Male  |  | 4. RACE White               |  | 5. DATE OF BIRTH MONTH DAY YEAR JUL 10 1955   |  | 6. AGE (IN YEARS LAST BIRTHDAY) 24 YRS.  |  | 7. IF UNDER 1 YR. MONTHS DAYS  |  | 7. IF UNDER 24 HRS. HOURS MIN   |  |                                     |  |
| 1a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND   |  |                             |  | 7b. CITIZEN OF WHAT COUNTRY? USA  |  |  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City, MD.  |  |                                     |  |
| 10. CITY OR TOWN OF DEATH Baltimore  |  |                             |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) University Hospital (STU) |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) UNEMPLOYED   |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |                                     |  |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |                             |  |   |  |  |  |  |  | 13a. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>    |  | 13b. STREET ADDRESS 9132 SIMMS AVE. |  |
| 13a. STATE MARYLAND  |  | 13b. CITY OR TOWN BALTIMORE |  | 13c. CITY OR TOWN PARKVILLE   |  | 14. FATHER'S NAME FIRST MIDDLE LAST DOUGLAS W. MATHENY SR.   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST JEANNE EDWARDS  |  |   |  |                                     |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO  |  |                             |  | 16b. SOCIAL SECURITY NO. 317-64-1661  |  | 17. INFORMANT FAMILY   |  | ADDRESS  |  |   |  |                                     |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Fracture of cervical spine<br>8/120<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b) DUE TO, OR AS A CONSEQUENCE OF<br>(c) DUE TO, OR AS A CONSEQUENCE OF<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |                             |  |   |  |  |  |  |  |   |  |                                     |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).  |  |                             |  |   |  |  |  |  |  |   |  |                                     |  |
| 19a. DATE OF OPERATION   |  |                             |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |  |  |  |  |  | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                |  |                                     |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |  |                             |  | 21b. TIME OF INJURY HOUR MIN MONTH DAY YEAR 4:10 P.M. 12 7 19 79  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) Driver of auto/auto impact |  |  |  |   |  |                                     |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>  |  |                             |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) street  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE Joppa Road Perry Hall, Baltimore, Md.                     |  |  |  |   |  |                                     |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |  |                             |  |   |  |  |  |  |  |   |  |                                     |  |
| ACTUAL SIGNATURE Virginia L. Dolan   |  |                             |  | TITLE (SPECIFY) Assistant   |  |  |  | M.D. MEDICAL EXAMINER  |  | DATE SIGNED 12/8/79   |  |                                     |  |
| EXAMINER'S NAME (TYPE OR PRINT) Virginia L. Dolan, M.D.  |  |                             |  | ADDRESS 111 Penn Street   |  |  |  |  |  |   |  |                                     |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL   |  |                             |  | 23b. DATE DEC. 10, 1979   |  | 23c. NAME OF CEMETERY OR CREMATORY PARKWOOD  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE BALTO. COUNTY MD.  |  |   |  |                                     |  |
| 24. FUNERAL DIRECTOR NAME EVANS FUNERAL CHAPEL   |  |                             |  | ADDRESS 8800 HARFORD RD   |  | 25a. DATE REC'D BY REGISTRAR DEC 13 1979   |  | 25b. REGISTRAR'S SIGNATURE   |  |   |  |                                     |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  |   |  |  |  |   |  |  |  |
|---|--|--|--|---|--|--|--|---|--|--|--|
| 1- FOR STATE REGISTRAR  |  | Louis  |  | 7 9 3 0 3 8 1   |  | REG. NO.   |  |   |  |  |  |
| 1. DECEASED NAME (TYPE OR PRINT)  |  | FIRST  |  | MIDDLE  |  | LAST   |  | 2r. DATE OF DEATH MONTH DAY YEAR  |  | 2b. HOUR MIN                                 |  |
| (2) (Lewis)   |  | Heroy  |  | MATTHEWS, SR.   |  |  |  | 12 12 79  |  | 6 35 P M                                     |  |
| 3 SEX   |  | 4-RACE   |  | 5 DATE OF BIRTH MONTH DAY YEAR  |  | 6 AGE (IN YEARS LAST BIRTHDAY)   |  | 7 UNDER 1 YEAR MONTHS DAYS  |  | 7b. UNDER 24 HRS. HOURS MIN.                 |  |
| Male  |  | NEGRO  |  | 5 27 14   |  | 65 YRS.  |  |   |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD.                                    |  |   |  |  |  |
| 10 CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |   |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)   |  | 12b. KIND OF BUSINESS OR INDUSTRY            |  |
| BALTIMORE   |  | ST. AGNES HOSPITAL   |  |   |  |  |  |   |  |  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  | 13b. STATE   |  | 13c. CITY OR TOWN   |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS   |  |  |  |
| Maryland  |  | Baltimore  |  | Baltimore   |  | YES  |  | 405 Commonwealth Avenue   |  |  |  |
| 14 FATHER'S NAME FIRST MIDDLE LAST  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST   |  |   |  |  |  |   |  |  |  |
| Charles   |  | Matthew  |  | Mary  |  | Adams  |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)   |  | 16b. SOCIAL SECURITY NO  |  | 17 INFORMANT  |  | ADDRESS  |  |   |  |  |  |
| No  |  | 220-07 8093  |  | Doris Matthews  |  | 405 Commonwealth Avenue  |  |   |  |  |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>ACUTE MYOCARDIAL INFARCTION</u><br>410-<br>DUE TO, OR AS A CONSEQUENCE OF (b) <u>OCCCLUSION CORONARY ARTERIES (2) (2)</u><br>DUE TO, OR AS A CONSEQUENCE OF (c) <u>ATHEROSCLEROSIS</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |  |  |   |  |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a.<br><u>HISTIOCYTIC MEDULLARY RETICULOSIS; RENAL CELL CARCINOMA</u>   |  |  |  |   |  |  |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>                       |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |   |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |  |  |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |  |  |   |  |  |  |   |  |  |  |
| 22b. SIGNATURE  |  | DEGREE   |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>              |  |  |  | 22c. DATE SIGNED  |  |  |  |
| Michael E. Pelczar MD   |  |  |  |   |  |  |  | 12/13   |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  | 22e. ADDRESS   |  |   |  |  |  |   |  |  |  |
| MICHAEL E. PELCZAR  |  | 900 CATON AVE. BALTIMORE, MD. 21229  |  |   |  |  |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE  |  |   |  |  |  |
| Burial  |  | 12/17/1979   |  | Western Star Cemetery   |  | Baltimore Maryland   |  |   |  |  |  |
| 24. FUNERAL DIRECTOR NAME ADDRESS   |  | 25. DATE REC'D. BY REGISTRAR   |  | 25b. REGISTRAR'S SIGNATURE  |  |  |  |   |  |  |  |
| Wm. C. March F/H 1101 East North Avenue   |  | DEC 14 1979  |  | Dorothy McCready  |  |  |  |   |  |  |  |

1880

(1112)

BALTIMORE CITY

W. 2. 4.

Maryland

ST. AGNES HOSPITAL

BALTIMORE

AT THE MEDICAL INVESTIGATION  
OF THE COMPANY ARRESTED (1112)

AT THE MEDICAL INVESTIGATION

AT THE MEDICAL INVESTIGATION

11/11

Michael J. [illegible]

MICHAEL J. [illegible] 300 CATON AVE. BALTIMORE, MD. 2122

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH7 9 3 0 3 8 2  
REG. NO.FOR  
1 - STATE  
REGISTRAR

|  |  |   |  |   |                                       |  |
|--|--|---|--|---|---------------------------------------|--|
| 1. DECEASED NAME (TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>Ernest G. Mattiucci</b>  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>12 5 79</b>                  |   | 2b. HOUR<br><b>9 PM</b>               |  |
| 3 SEX<br><b>Male</b>   | 4 RACE<br><b>White</b>   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>10/18/1901</b>   |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br><b>78</b> YRS.  |                                       | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Italy</b>  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>Italy</b>   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore city</b> MD.   |                                       |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Baltimore City Hospitals</b> |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Self-Employed</b>  |                                       | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Fencing</b>  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>Md.</b>  |  |   | 13b. COUNTY<br><b>-----</b>  |   | 13c. CITY OR TOWN<br><b>Baltimore</b> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Gennaio Mattiucci</b>   |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Flavia Unknown</b> |   |                                       |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>213.05.9496</b>  |  | 17. INFORMANT<br>ADDRESS<br><b>Harold Stephen Patton</b><br><b>3104 Parkside Dr. Balto., Md. 21214</b>  |                                       |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiopulmonary arrest</b><br><b>1991</b><br>DUE TO, OR AS A CONSEQUENCE OF:<br>(b) <b>metastatic adenocarcinoma</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(c) _____<br>DUE TO, OR AS A CONSEQUENCE OF _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |   |  |   |                                       |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1.<br><b>Anemia Hypertension Congestive Heart Failure</b>  |  |   |  |   |                                       |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                                       | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |                                       |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |                                       |  |
| 22a. I certify that (this hospital) attended the deceased from <b>Oct. 30, 1979</b> to <b>Dec 5, 1979</b> , that (we) lost<br>saw the deceased alive on <b>Dec 5, 1979</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above; (I) (we) did (did not) view the body after death.   |  |   |  |   |                                       |  |
| 22b. SIGNATURE<br><b>Richard Burnett</b>   |  | 22c. DATE SIGNED<br><b>12/5/79</b>  |  | 22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |                                       |  |
| 22e. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Richard Burnett</b>  |  | 22f. ADDRESS<br><b>Dept of Medicine Balt City Hosp.</b>   |  |   |                                       |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Cremation</b>   |  | 23b. DATE<br><b>12/7/1979</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Green Mount</b>  |                                       | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Md.</b>   |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Walter Brooks Bradley Inc.</b>  |  | ADDRESS<br><b>Dundalk, Md.</b>  |  | 25a. DATE REC'D BY REGISTRAR<br><b>DEC 10 1979</b>  |                                       | 25b. REGISTRAR'S SIGNATURE<br><b>Antony McCreedy</b>   |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.







TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

7 9 3 0 3 8 3

REG. NO.

|  |  |  |   |  |                                  |  |         |
|--|--|--|---|--|----------------------------------|--|---------|
| 1- FOR STATE REGISTRAR   |  | 2a DATE OF DEATH   |   | MONTH  | DAY                              | YEAR   | 2b HOUR |
| 1. DECEASED NAME (TYPE OR PRINT)   |  | FIRST  | MIDDLE  | LAST   |                                  |  |         |
| Warren Y. Mays   |  |  |   |  |                                  | 12 18 79 8:38 AM   |         |
| 3. SEX   | 4. RACE  | 5. DATE OF BIRTH   |   | 6. AGE (IN YEARS LAST BIRTHDAY)  |                                  | 7. IF UNDER 1 YEAR   |         |
| male   | Caucasian  | MONTH DAY YEAR   |   | 56 YRS.  |                                  | MONTHS DAYS HOURS MIN  |         |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)   | 7b CITIZEN OF WHAT COUNTRY?  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH   |                                  |  |         |
| Maryland   | USA  |  |   | Balto City MD.   |                                  |  |         |
| 10 CITY OR TOWN OF DEATH   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)        |  | 12b KIND OF BUSINESS OR INDUSTRY |  |         |
| Balto  | Sinai Hosp.  |  | Self Employed   |  | Appliance                        |  |         |
| 13a. STATE   |  | 13b. COUNTY  | 13c. CITY OR TOWN   | 13d. INSIDE CITY LIMITS?   | 13e. STREET ADDRESS              |  |         |
| MD   | Balto  | Towson   | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 8341 Carrbridge Circle   |                                  |  |         |
| 14. FATHER'S NAME  |  | 15. MOTHER'S MAIDEN NAME   |   |  |                                  |  |         |
| FIRST MIDDLE LAST  |  | FIRST MIDDLE LAST  |   |  |                                  |  |         |
| Charles Mays   |  | Myrtle Young   |   |  |                                  |  |         |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)  |  | 16b. SOCIAL SECURITY NO.   |   | 17. INFORMANT ADDRESS  |                                  |  |         |
| Yes  |  | WW II  |   | Mrs. Caroline Mays 8341 Carrbridge Circle  |                                  |  |         |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)  |  | 410 - acute myocardial infarction  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |                                  |  |         |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.   |  | b) a.s.c.u.  |   | 3 hours  |                                  |  |         |
| c)   |  |  |   |  |                                  |  |         |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |  |   |  |                                  |  |         |
| interior ME 24050  |  |  |   |  |                                  |  |         |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   | 20a. AUTOPSY?  |                                  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |         |
|  |  |  |   | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                                  | YES <input type="checkbox"/> NO <input type="checkbox"/>       |         |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |                                  |  |         |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |                                  |  |         |
| 22a. I certify that (I) (this hospital) attended the deceased from 12/18/79 to 12/18/79, that (I) (we) last saw the deceased alive on 12/18/79, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. |  | 22b. SIGNATURE   |   | DEGREE   |                                  | 22c. DATE SIGNED   |         |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  | 22e. ADDRESS   |   | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |                                  | 12/18/79   |         |
| Stuart Ross  |  | 10119 S. Dorfield Rd Owings Mills 21117  |   |  |                                  |  |         |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |  | 23b. DATE  |   | 23c. NAME OF CEMETERY OR CREMATORY   |                                  | 23d. LOCATION CITY OR TOWN COUNTY STATE                        |         |
| Burial   |  | 12/20/79   |   | Dulaney Valley Cemetery  |                                  | Baltimore Maryland   |         |
| 24. FUNERAL DIRECTOR NAME  |  | ADDRESS  |   | 25a. DATE REC'D. BY REGISTRAR  |                                  | 25b. REGISTRAR'S SIGNATURE                                     |         |
| Ruck Towson Funeral Home, Inc. 1050 York Road  |  |  |   | DEC 20 1979  |                                  | [Signature]  |         |

BP





TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PA 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP  
DHMH - 17  
(VR 15 ME (5))  
30M 7/73

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH   |  |   |  |   |  |  |  |  |  | REG. NO. 30384   |  |
|---|--|---|--|---|--|--|--|--|--|--|--|
| 1. FOR STATE REGISTRAR  |  | 1. DECEASED NAME (TYPE OR PRINT) <b>Emile A. Mayock</b>   |  |   |  |  |  | 2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH DAY YEAR <b>12 18 1979</b> |  | 2b. HOUR <b>M</b>  |  |
| 3. SEX <b>Female</b>  |  | 4. RACE <b>White</b>  |  | 5. DATE OF BIRTH MONTH DAY YEAR <b>11-14-10</b>             |  | 6. AGE (IN YEARS) LAST BIRTHDAY <b>69</b> YRS.   |  | IF UNDER 1 YR. MONTHS DAYS HOURS MIN   |  | 2c. DATE PRONOUNCED DEAD <b>12 18 1979</b>                                       |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>   |  | 7b. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>  |  |   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City, MD.</b>                              |  |  |  |
| 10. CITY OR TOWN OF DEATH <b>Baltimore</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>1333 E. Clement Street</b> |  |   |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Cashier</b>                 |  | 12b. KIND OF BUSINESS <b>Verdier</b>   |  |
| 13a. STATE <b>Maryland</b>  |  | 13b. COUNTY <b>-</b>  |  | 13c. CITY OR TOWN <b>Baltimore</b>                          |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 13e. STREET ADDRESS <b>1333 E. Clement St.</b>   |  |  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST <b>Daniel Lippy</b>   |  |   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Fallon</b>    |  |  |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>No</b>  |  |   |  | 16b. SOCIAL SECURITY NO. <b>213-18-7667</b>                 |  | 17. INFORMANT ADDRESS <b>William E. Kennedy, Jr 1333 E. Clement St.</b>  |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1 DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Arteriosclerotic Cardiovascular Disease</b><br><b>4292</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____  |  |   |  |   |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                     |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).   |  |   |  |   |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION  |  |   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?           |  |  |  |  |  | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |  |   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b> |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)  |  |  |  |  |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |  |  |  |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: <b>Natural causes</b> <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . |  |   |  |   |  |  |  |  |  |  |  |
| ACTUAL SIGNATURE <b>Virginia L. Dolan</b>   |  |   |  | TITLE (SPECIFY) <b>Assistant</b>                            |  |  |  | DATE SIGNED <b>12/18/79</b>  |  |  |  |
| EXAMINER'S NAME (TYPE OR PRINT) <b>Virginia L. Dolan, M.D.</b>  |  |   |  | ADDRESS <b>111 Penn Street</b>                              |  |  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>   |  | 23b. DATE <b>12-21-79</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY <b>Parkwood Cemetery</b> |  |  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore Maryland</b>                            |  |  |  |
| 24. FUNERAL DIRECTOR NAME <b>Charles L. Stevens</b>   |  |   |  | ADDRESS <b>Funeral Home, Inc., 1501 E. Fort Ave.</b>        |  |  |  | 25a. DATE REC'D. BY REGISTRAR <b>DEC 21 1979</b>   |  | 25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>                                    |  |

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| 1. DECEASED NAME<br>(TYPE OR PRINT)  |     | FIRST                        | MIDDLE   | LAST | 2a. DATE OF DEATH  | MONTH  | DAY   | YEAR   | 2b. HOUR |
|--|-----|------------------------------|--|------|--|--|---|--|----------|
| MARY A McCaull   |     |                              |  |      | 12/28/79   | 12   | 28  | 79   | 1:30 PM  |
| 3. SEX   | F   | 4. RACE                      | WHITE  |      | 5. DATE OF BIRTH   | MONTH  |   | DAY  | YEAR     |
|  |     |                              |  |      |  | JULY   |   | 14   | 1903     |
| 6. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)  | MD. | 7b. CITIZEN OF WHAT COUNTRY? | U.S.A.   |      | 8. MARRIED   | NEVER MARRIED  |   | DIVORCED   |          |
|  |     |                              |  |      | WIDOWED  | <input checked="" type="checkbox"/>  |   | <input type="checkbox"/>   |          |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE   |     |                              |  |      | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD.   |  |   |  |          |
| 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>ST. AGNES HOSPITAL  |     |                              |  |      | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>HOUSEWIFE  |  |   |  |          |
| 12b. KIND OF BUSINESS OR INDUSTRY  |     |                              |  |      |  |  |   |  |          |
| 13a. STATE<br>MD.  |     |                              |  |      | 13b. COUNTY<br>BALTO.  |  |   |  |          |
| 13c. CITY OR TOWN<br>BALTO.  |     |                              |  |      | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  |   |  |          |
| 13e. STREET ADDRESS<br>3027 FREDERICK AVE.   |     |                              |  |      |  |  |   |  |          |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>JOSEPH HASEL BELGER  |     |                              |  |      | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>MARY ANN McKENNA  |  |   |  |          |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>NO   |     |                              |  |      | 16b. SOCIAL SECURITY NO.<br>214-50-6781  |  |   |  |          |
| 17. INFORMANT<br>ADDRESS<br>CATHERINE BALL 942 ELM RIDGE AVE 21229   |     |                              |  |      |  |  |   |  |          |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |     |                              |  |      |  |  |   |  |          |
| PART I. DEATH WAS CAUSED BY:   |     |                              |  |      |  |  |   |  |          |
| IMMEDIATE CAUSE (a) Sepsis - peritonitis - perforated abdominal viscera  |     |                              |  |      |  |  |   |  |          |
| DUE TO, OR AS A CONSEQUENCE OF (b) Pancreatic Carcinoma  |     |                              |  |      |  |  |   |  |          |
| DUE TO, OR AS A CONSEQUENCE OF (c) widespread metastases   |     |                              |  |      |  |  |   |  |          |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)  |     |                              |  |      |  |  |   |  |          |
| 19a. DATE OF OPERATION<br>11/27/79   |     |                              | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br>Pancreatic Carcinoma |      |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |          |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |     |                              | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19               |      |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART 1 OR PART 2)       |   |  |          |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |     |                              | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |      |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |   |  |          |
| 22a. I certify that (this hospital) attended the deceased from 11/05/79, 19, to 12/27/79, 19, that (s/he) (we) lost saw the deceased alive on 11/27/79, 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (s/he) (did) (did not) view the body after death. |     |                              |  |      |  |  |   |  |          |
| 22b. SIGNATURE<br>Seema Ahsan Khan   |     |                              |  |      | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  |   | 22c. DATE SIGNED<br>12/28/79   |          |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>SEEMA AHSAN KHAN  |     |                              |  |      | 22e. ADDRESS<br>900 S. CATON AVE - Balto, Md. 21229  |  |   |  |          |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>BURIAL   |     |                              | 23b. DATE<br>12-31-79  |      | 23c. NAME OF CEMETERY OR CREMATORY<br>LONDON PARK CEM.   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>BALTO MD. |  |          |
| 24. FUNERAL DIRECTOR<br>NAME<br>FARLEY F.H. 6601 FRED. AVE.  |     |                              |  |      | 25a. DATE REC'D. BY REGISTRAR<br>JAN 2 1980  |  | 25b. REGISTRAR'S SIGNATURE<br>[Signature]               |  |          |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the funeral director. Page 3 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 50M 7/77  
(VR A 15 (4))STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

7 9 3 0 3 8 6

REG. NO.

|  |  |   |  |   |  |  |  |
|--|--|---|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  | FIRST MIDDLE LAST<br><b>James W. McClellan</b>  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>12 04 79</b>   |  | 2b. HOUR<br><b>1:58 P.M.</b>   |  |
| 3. SEX<br><b>Male</b>  |  | 4. RACE<br><b>Negro</b>   |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>OCT 03 1903</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>76</b> YRS.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>S.C.</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore, Md.</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Bon Secours</b> |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Construction</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| 13a. STATE<br><b>Md.</b>   |  | 13b. COUNTY   |  | 13c. CITY OR TOWN<br><b>Balto.</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |  |
| 13e. STREET ADDRESS<br><b>1606 Riggs Avenue -21217</b>   |  | 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>Paul McClellan</b>  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>Rachell</b>  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>249-05-7503</b>   |  | 17. INFORMANT<br><b>Janie McClellan</b>   |  | ADDRESS<br><b>1606 Riggs Ave-21217</b>   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br><b>1588</b> IMMEDIATE CAUSE (a) <b>CA of mesentery</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>CVA</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(c) <b>yrs</b><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>2 M.</b> |  |   |  |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)  |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |
| 22a. I certify that (I) (hus-band) attended the deceased from <b>Oct 09</b> , 19 <b>79</b> , to <b>Dec 04</b> , 19 <b>79</b> , that (I) (we) last saw the deceased alive on <b>Dec 4</b> , 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.   |  |   |  |   |  |  |  |
| 22b. SIGNATURE<br><b>Kuang-yen Huang</b>   |  | DEGREE<br><b>M.D.</b>   |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                  |  | 22c. DATE SIGNED<br><b>12/05/79</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>KUANG-YEN HUANG</b>  |  | 22e. ADDRESS<br><b>BON Secours Hosp Balto 21223</b>   |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>12/10/79</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Md. National Mem.Pk.</b>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Laurel Maryland</b>   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>VERNON R. BAILEY</b>  |  | ADDRESS<br><b>1348 N. CALHOUN STREET</b>  |  | 25. DATE RECEIVED BY REGISTRAR<br><b>DEC 7 1979</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>L. H. McLeod</b>  |  |

MEDICAL CERTIFICATION

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• **Test 1**

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FOR  
1 - STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |   |   |                   |                                      |   |               |                                   |      |          |
|--|---|---|-------------------|--------------------------------------|---|---------------|-----------------------------------|------|----------|
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |   | FIRST   | MIDDLE            | LAST                                 | 2a. DATE OF DEATH   | MONTH         | DAY                               | YEAR | 2b. HOUR |
| Brady  |   | EARL  |                   | McCoy                                | 12-08-79  |               |                                   |      | 11 P.M.  |
| 3. SEX   | 4. RACE   | 5. DATE OF BIRTH  |                   | 6. AGE (IN YEARS LAST BIRTHDAY)      | IF UNDER 1 YEAR   |               | IF UNDER 24 HRS                   |      |          |
| Male   | White   | March 9, 1932   |                   | 47                                   | MONTHS  |               | DAYS                              |      |          |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  | 7b. CITIZEN OF WHAT COUNTRY?  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                   | 9. BALTIMORE CITY OR COUNTY OF DEATH |   |               |                                   |      |          |
| VA.  | U.S.A.  |   |                   | Baltimore City                       |   |               |                                   |      |          |
| 10. CITY OR TOWN OF DEATH  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |   |                   |                                      | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)    |               | 12b. KIND OF BUSINESS OR INDUSTRY |      |          |
| Baltimore  | The Johns Hopkins Hospital  |   |                   |                                      | Machineist  |               | Mfg.                              |      |          |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) |   | 13b. COUNTY   | 13c. CITY OR TOWN |                                      | 13d. INSIDE CITY LIMITS?  |               | 13e. STREET ADDRESS               |      |          |
| Md.  |   | -   | Baltimore         |                                      | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |               | 1727 McHenry St                   |      |          |
| 14. FATHER'S NAME  |   | 15. MOTHER'S MAIDEN NAME  |                   |                                      |   |               |                                   |      |          |
| Wm Henry McCoy   |   | Emma Mae Pears  |                   |                                      |   |               |                                   |      |          |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)                         |   | 16b. SOCIAL SECURITY NO.  |                   | 17. INFORMANT                        |   | ADDRESS       |                                   |      |          |
| No   |   | 229 34 1578   |                   | Virginia McCoy                       |   | Baltimore Md. |                                   |      |          |

|  |  |   |
|--|--|---|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY: |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |
| IMMEDIATE CAUSE (a) DEATH OF UNKNOWN ETIOLOGY  |  |   |
| 7999   |  |   |
| DUE TO, OR AS A CONSEQUENCE OF   |  |   |
| (b) EAR MYOCARDIAL DISEASE   |  |   |
| DUE TO, OR AS A CONSEQUENCE OF   |  |   |
| (c)  |  |   |

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

|  |  |  |   |
|--|--|--|---|
| 19a. DATE OF OPERATION   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       | 20a. AUTOPSY?  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH? |
|  |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>            | YES <input type="checkbox"/> NO <input type="checkbox"/>          |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |   |
|  |  |  |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |   |
|  |  |  |   |

22. I certify that (this hospital) attended the deceased from 11/24, 1979, to 12/8, 1979, that (we) last saw the deceased alive on 12/8, 1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) (did) (did not) view the body after death.

|                                       |                      |                  |
|---------------------------------------|----------------------|------------------|
| 22a. SIGNATURE                        | DEGREE               | 22c. DATE SIGNED |
| Elliott Israel                        | MD                   | 4/8/79           |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | 22e. ADDRESS         |                  |
| Elliott Israel                        | 601 N BROADWAY 21205 |                  |

|  |                                 |                                    |  |
|--|---------------------------------|------------------------------------|--|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY) | 23b. DATE                       | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE |
| Burial                                       | 12-13-79                        | McCoy Family Cemetery              | St. Paul Va.                               |
| 24. FUNERAL DIRECTOR<br>NAME                 | 25a. DATE RECEIVED BY REGISTRAR |                                    | 25b. REGISTRAR'S SIGNATURE                 |
| Harry W. Haight                              | DEC 12 1979                     |                                    | Harry W. Haight                            |
| ADDRESS                                      |                                 |                                    |  |
| Lakewood, Md.                                |                                 |                                    |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 and 5a should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the funeral director with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

F11MG58 12/31/79 ka

STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

7 9 3 0 3 8 8

|  |  |   |   |   |   |  |   |
|--|--|---|---|---|---|--|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT) FIRST MIDDLE LAST<br><b>McCray, B. Elijah</b>  |  |   | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>12/25/79</b> |   |   | 2b. HOUR<br><b>5:10 PM</b>   |   |
| 3. SEX<br><b>m</b>   |  | 4. RACE<br><b>B</b>   |   | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>4 15 21</b>   |   | 6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS HOURS MIN<br><b>58</b> YRS |   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>S.C.</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.      |   |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>LUTHERAN HOSPITAL</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)  |   | 12b. KIND OF BUSINESS OR INDUSTRY                                      |   |
| 13a. STATE<br><b>Maryland</b>  |  | 13b. COUNTY<br><b>Baltimore</b>   |   | 13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |   | 13d. STREET ADDRESS<br><b>2711 Presbury St.</b>                        |   |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>TALBERT</b>  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>ROSA BENJAMIN</b>  |   |   |   |  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br><b>No</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>251-26-6130</b>  |   | 17. INFORMANT ADDRESS<br><b>Daisy McCray, 2711 Presbury St.</b>   |   |  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiovascular Collapse</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (b) <b>Hypoxic Encephalopathy</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)                              |  |   |   |   |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>4 days</b><br><b>4 days</b>  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><b>TB Malnutrition</b>  |  |   |   |   |   |  |   |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   |   | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |   |  |   |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |   | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |   |  |   |
| 22a. I certify that (1) this hospital attended the deceased from <b>12/16</b> , 19 <b>79</b> , to <b>12/25</b> , 19 <b>79</b> , that (2) we last saw the deceased alive on <b>12/25</b> , 19 <b>79</b> , and that in (my/our) opinion death occurred on the date and hour and from the causes stated above. (If (we) did not view the body after death, so state.) |  |   |   |   |   |  |   |
| 22b. SIGNATURE<br><b>Richard J. Diamond</b>  |  | DEGREE<br><b>MD</b>   |   | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>                  |   | 22c. DATE SIGNED<br><b>12/25/79</b>                                    |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>RICHARD DIAMOND</b>  |  | 22e. ADDRESS<br><b>Lutheran Hospital</b>  |   |   |   |  |   |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>12-31-79</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>BALTIMORE CEM.</b>   |   | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><b>BALTIMORE MD.</b>        |   |
| 24. FUNERAL DIRECTOR NAME<br><b>Wm. C. March F/H</b>   |  |   |   | ADDRESS<br><b>1101 E. North Ave.</b>  |   | 25a. DATE REC'D. BY REGISTRAR<br><b>DEC 28 1979</b>                    |   |
| 25b. REGISTRAR'S SIGNATURE<br><b>Robert M. Kelly</b>   |  |   |   |   |   |  |   |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |  |  |
|--|--|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>EDWARD L. McCULLOUGH   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>12 6 79   |  | 2b. HOUR<br>2:30 AM  |  |
| 3. SEX<br>M  |  | 4. RACE<br>WHITE   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>11 12 1919   |  |
| 6. AGE (IN YEARS LAST BIRTHDAY)<br>60 YRS.   |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS  |  | 8. IF UNDER 24 HRS<br>HOURS MIN  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>MD.   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore CITY MD.   |  |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>UNION MEMORIAL HOSPITAL   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>TECHNICIAN   |  |
| 12b. KIND OF BUSINESS OR INDUSTRY<br>C+P.  |  | 13a. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 13b. STREET ADDRESS<br>701 SUDBROOK RD.  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>EDWARD L. McCULLOUGH   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>HELEN ANDREWS   |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>YES  |  |
| 16b. SOCIAL SECURITY NO<br>(IF YES, GIVE WAR OR NAVY)<br>WWTII   |  | 17. INFORMANT<br>ADDRESS<br>MARY O. McCULLOUGH SAME 21201  |  | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Staphylococcal Septicemia</u><br>2028<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Non-Hodgkin Lymphoma</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u></u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |
| APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>7 days<br>10 yrs.  |  |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a) <u></u> |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                   |  | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  | 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  |
| 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  | 22a. I certify that (if this hospital) attended the deceased from <u>12 11</u> 19 <u>77</u> , to <u>12 16</u> 19 <u>79</u> , that (I/we) last saw the deceased alive on <u>12 16</u> 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  | 22b. SIGNATURE<br>Michael N. Rubinstein MD.<br>DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>  |  |
| 22c. DATE SIGNED<br>12/6/79  |  | 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Michael N. Rubinstein   |  | 22e. ADDRESS<br>201 E. University Pkwy.  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>BURIAL   |  | 23b. DATE<br>12-10-79  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>DRUID RIDGE  |  |
| 23d. LOCATION<br>CITY OR TOWN<br>BALTO. CO. MD.  |  | 24. FUNERAL DIRECTOR<br>NAME<br>NEWELL F.H.  |  | 25a. DATE REC'D. BY REGISTRAR<br>DEC 11 1979   |  |
| 25b. REGISTRAR'S SIGNATURE<br>[Signature]  |  |  |  |  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  | REG. NO. 7 9 3 0 3 9 0   |  |   |  |
|--|--|--|--|--|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) <b>FOR STATE REGISTRAR</b><br>FIRST <b>Anne</b> MIDDLE <b>Elizabeth</b> LAST <b>McGee</b><br><i>ANNE Elizabeth McGEE</i>  |  |  |  | 2a. DATE OF DEATH MONTH <b>12</b> DAY <b>28</b> YEAR <b>79</b>   |  | 2b. HOUR <b>6:30 AM</b>   |  |
| 3. SEX <b>Female</b>   |  | 4. RACE <b>White</b>   |  | 5. DATE OF BIRTH MONTH <b>02</b> DAY <b>22</b> YEAR <b>13</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY) <b>66</b> YRS <b>8</b> MONTHS <b>8</b> DAYS <b>1</b> HOURS <b>1</b> MIN                 |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>West Virginia</b>   |  | 7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.  |  |
| 10. CITY OR TOWN OF DEATH <b>Baltimore</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Baltimore City Hospitals</b> |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Waitress</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) <b>Maryland</b>   |  |  |  | 13b. COUNTY <b>Baltimore</b>   |  | 13c. CITY OR TOWN <b>Dundalk</b>  |  |
| 14. FATHER'S NAME FIRST <b>Harvey</b> MIDDLE <b>McCully</b> LAST <b>McCully</b>  |  |  |  | 15. MOTHER'S MAIDEN NAME FIRST <b>Ruth A.</b> MIDDLE <b>Rix</b> LAST <b>Rix</b>  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>  |  | 16b. SOCIAL SECURITY NO. <b>215-24-6931</b>  |  | 17. INFORMANT ADDRESS <b>7470 Rabon Ave. Balto. MD 21222</b>   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiopulmonary arrest</b><br><b>4275</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost } DUE TO, OR AS A CONSEQUENCE OF (c) _____<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): |  |  |  |  |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)   |  |   |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>Dec 27</b> 19 <b>79</b> , to <b>Dec 28</b> 19 <b>79</b> , that (I) (we) last saw the deceased alive on <b>Dec 28</b> 19 <b>79</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) did not view the body after death.   |  |  |  |  |  |   |  |
| 22b. SIGNATURE <b>Sandra M. Walden MD</b>  |  | DEGREE <b>MD</b>   |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>               |  | 22c. DATE SIGNED <b>12/28/79</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>SANDRA M. WALDEN, MD</b>  |  | 22e. ADDRESS <b>BALTIMORE CITY HOSP</b>  |  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>  |  | 23b. DATE <b>12/31/79</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY <b>Meadowridge Mem.</b>   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE <b>Dorsey Maryland</b>  |  |
| 24. FUNERAL DIRECTOR NAME <b>Duda Ruck</b>   |  | ADDRESS <b>7922 Wise Avenue</b>  |  | 25a. DATE REC'D. BY REGISTRAR <b>JAN 3 1980</b>  |  | 25b. REGISTRAR'S SIGNATURE <b>Anthony McCreedy</b>  |  |

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |   |   |   |  |   |   |  |  |
|---|--|--|---|---|---|--|---|---|--|--|
| 1. FOR STATE REGISTRAR  |  |  |   |   | REG. NO.  |  |   |   |  |  |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br><b>BERTINA MCGOWAN</b>  |  |  |   |   | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>12 20 79</b>             |  |   |   |  |  |
| 3 SEX<br><b>FEMALE</b>  |  | 4 RACE<br><b>BLACK</b>   |   | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>2 27, 1901</b>  |   | 6 AGE (IN YEARS LAST BIRTHDAY)<br><b>78</b>  |   | 7b. HOUR<br><b>2:15 AM</b>  |  |  |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MARYLAND</b>   |  | 7b CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE</b>                                    |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>HOUSEWIFE</b>   |  |  |
| 10 CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>UNIVERSITY OF MARYLAND HOSP</b> |   |   |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>HOUSEWIFE</b>          |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>—</b>   |  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a STATE<br><b>MARYLAND</b>   |  |  |   |   | 13b COUNTY<br><b>BALTO. CITY</b>                                |  | 13c CITY OR TOWN<br><b>BALTIMORE</b>                                |   | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 14 FATHER'S NAME FIRST MIDDLE LAST<br><b>SAMUEL MAYNARD</b>   |  |  |   |   | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>LUCY MANER</b> |  |   |   |  |  |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br><b>NO</b>   |  |  |   |   | 16b SOCIAL SECURITY NO.<br><b>215-32-039</b>                    |  | 17 INFORMANT ADDRESS<br><b>Ardella Grant 2411 Albion Ave.</b>       |   |  |  |
| 18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>BRONCHOPNEUMONIA</b><br><b>1991</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(b) <b>OCCULT MALIGNANCY</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>—</b><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>8 HRS</b><br><b>6 MO.</b> |  |  |   |   |   |  |   |   |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><b>PSYCHOTIC DEPRESSION</b>  |  |  |   |   |   |  |   |   |  |  |
| 19a DATE OF OPERATION<br><b>NONE</b>  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                |   |   | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>                     |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)<br><b>—</b>  |  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><b>— P.M. 19</b>                |   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)<br><b>—</b> |   |   |  |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)<br><b>—</b> |   |   | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE<br><b>—</b>                                 |   |   |  |  |
| 22a I certify that (a) this hospital attended the deceased from <b>DEC. 7</b> , 19 <b>79</b> , to <b>DEC. 20</b> , 19 <b>79</b> , that (b) (we) lost saw the deceased alive on <b>DEC. 20</b> , 19 <b>79</b> , and that in (c) (our) opinion death occurred on the date and hour and from the causes stated above, (d) (we) (did not) view the body after death.  |  |  |   |   |   |  |   |   |  |  |
| 22b. SIGNATURE<br><b>Andrew P. Fridderl MD</b>  |  |  |   |   |   | DEGREE<br><b>—</b>   |   | 22c. DATE SIGNED<br><b>12/20/79</b>   |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>ANDREW FRIDDERL MD</b>  |  |  |   |   |   | 22e. ADDRESS<br><b>UNIV. MD. HOSP. BALTO. MD</b>   |   |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>  |  |  | 23b. DATE<br><b>12/20/1979</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Arbutus Mem. Park</b>  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><b>Arbutus, Maryland</b> |   |  |  |
| 24 FUNERAL DIRECTOR NAME<br><b>Wm. C. March F/H 1101 East North Avenue</b>  |  |  |   |   |   | 25a. DATE REC'D. BY REGISTRAR<br><b>DEC 21 1979</b>  |   | 25b. REGISTRAR'S SIGNATURE<br><b>Theresa McBrady</b>  |  |  |





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  |  |  | 7 9 3 0 3 9 2   |  |
|--|--|--|--|---|--|
| FOR<br>1 - STATE<br>REGISTRAR  |  |  |  | CERTIFICATE OF DEATH  |  |
| 1. DECEASED NAME   |  |  |  | 2a. DATE OF DEATH   |  |
| FIRST MIDDLE LAST<br>WILLIAM T. MCKENNEY   |  |  |  | MONTH DAY YEAR<br>12-27-79  |  |
| 3. SEX<br>Male   |  | 4. RACE<br>CAUC.   |  | 5. DATE OF BIRTH  |  |
|  |  |  |  | MONTH DAY YEAR<br>7-19-13   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>66   |  |
|  |  |  |  | IF UNDER 1 YEAR MONTHS DAYS<br>IF UNDER 24 HRS. HOURS MIN.                                      |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>MERCY Hosp. |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.                                      |  |
| 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Meat cutter  |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |   |  |
| 13a. STATE<br>Maryland   |  | 13b. COUNTY  |  | 13c. CITY OR TOWN<br>Baltimore  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Unknown McKenney   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Susie Kirby   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>216-05-8262   |  | 17. INFORMANT<br>ADDRESS<br>Mr. William McKenney, Same  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a)<br>410- PROBABLE ACUTE MI<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) ASCVD<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)  |  |  |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br>DM, COPD - yrs.   |  |  |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  |
| 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  |  |  |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 12-26-79 to 12-27-79, that (I) (we) saw the deceased alive on 12-27-79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we did not view the body after death, so state.) |  |  |  |   |  |
| 22b. SIGNATURE<br>Patricia Snello M.D.   |  | DEGREE   |  | 22c. DATE SIGNED<br>12/27/79.   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>PATRICIA SNELLO   |  | 22e. ADDRESS<br>MERCY HOSP.  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial   |  | 23b. DATE<br>Dec. 31, 1979   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Cedar Hill Cemetery                                       |  |
| 23d. LOCATION<br>CITY OR TOWN<br>Baltimore, Maryland   |  | 23e. DATE REC'D. BY REGISTRAR<br>DEC 28 1979   |  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>McElly Funeral Home, 130 E. Fort Ave. Balto. Md.   |  | 25a. DATE REC'D. BY REGISTRAR<br>DEC 28 1979   |  |   |  |





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified of once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |   |  |   |  |   |   |  |  |
|---|--|---|---|--|---|--|---|---|--|--|
| 1 - FOR STATE REGISTRAR   |  |   |   |  | REG. NO. 7 9 3 0 3 9 3  |  |   |   |  |  |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br>BABY BASTI MCNAIR   |  |   |   |  | 2a. DATE OF DEATH MONTH DAY YEAR 2b. HOUR<br>12 - 14 - 79 841 P M |  |   |   |  |  |
| 3 SEX<br>FEMALE   |  | 4 RACE<br>BLACK   |   | 5. DATE OF BIRTH MONTH DAY YEAR<br>12 14 79  |   | 6 AGE (IN YEARS LAST BIRTHDAY)<br>50 min   |   | 7. IF UNDER 1 YEAR IF UNDER 24 HRS.<br>MONTHS DAYS HOURS MIN<br>0 50  |  |  |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>MARYLAND  |  | 7b CITIZEN OF WHAT COUNTRY?<br>United States  |   | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD.   |   |   |  |  |
| 10 CITY OR TOWN OF DEATH<br>BALTIMORE   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>University of Maryland Hospital |   |  |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>-   |   | 12b. KIND OF BUSINESS OR INDUSTRY<br>-  |  |  |
| 13a. STATE<br>Maryland  |  |   |   |  | 13b. COUNTY<br>BALTIMORE  |  | 13c. CITY OR TOWN<br>Baltimore              |   | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>TERRY - MCNAIR   |  |   |   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Lucille REYNOLDS    |  |   |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>NO   |  |   |   | 16b. SOCIAL SECURITY NO.<br>-  |   | 17. INFORMANT ADDRESS<br>-   |   |   |  |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) ANENCEPHALY<br>7400<br>DUE TO, OR AS A CONSEQUENCE OF (b) _____<br>DUE TO, OR AS A CONSEQUENCE OF (c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |   |   |  |   |  |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>-  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |   |   |  |   |  |   |   |  |  |
| 19a. DATE OF OPERATION  |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                    |  |   | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |   |   |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  |   | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  |   | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |   |   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 12-14-79, to 12-14, 19 79, that (I) (we) last saw the deceased alive on 12-14, 19 79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                             |  |   |   |  |   |  |   |   |  |  |
| 22b. SIGNATURE<br>Glenn Cohen   |  |   |   |  |   | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |   | 22c. DATE SIGNED<br>12-14-79  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>G. COHEN MD  |  |   |   |  |   | 22e. ADDRESS<br>Union Memorial Hospital  |   |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Removal  |  |   | 23b. DATE<br>12/20/79   |  | 23c. NAME OF CEMETERY OR CREMATORY                                |  | 23d. LOCATION CITY OR TOWN COUNTY STATE     |   |  |  |
| 24. FUNERAL DIRECTOR NAME<br>Anatomy Board  |  |   |   |  | ADDRESS<br>Balto., Md.  |  | 25. DATE REC'D. BY REGISTRAR<br>DEC 20 1979 |   | 25b. REGISTRAR'S SIGNATURE<br>[Signature]  |  |



PREMIUM

100% COTTON



STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

7 9 3 0 3 9 4

REG. NO.

1- FOR  
STATE  
REGISTRAR

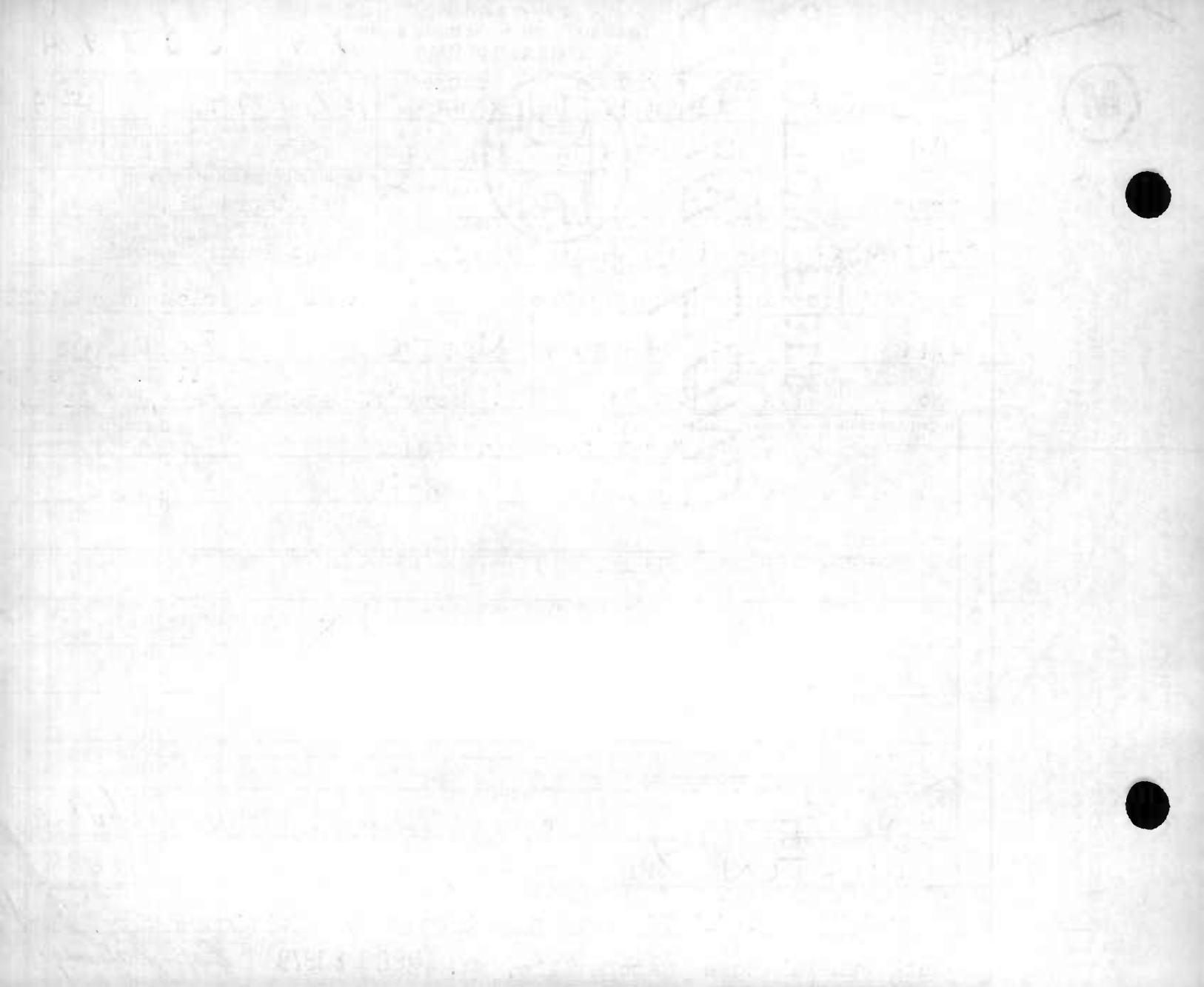
|  |   |   |  |   |   |
|--|---|---|--|---|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>CHARLES THOMAS MEACHAM</b>   |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>12/14/79</b>  |  | 2b. HOUR<br><b>3:44 A.M.</b>  |   |
| 3. SEX<br><b>M Male</b>  | 4. RACE<br><b>W White</b>   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>01 31 29</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>50</b> YRS.   |   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>   | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.   |   |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>West Maryland Hosp.</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Piano Tuner</b> |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Music</b> |
| 13a. STATE<br><b>Maryland</b>  |   | 13b. COUNTY<br><b>Baltimore</b>   | 13c. CITY OR TOWN<br><b>Catonsville</b>  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>HARRY D. MEACHAM</b>  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>NETTIE BOURLAND</b>   |  | 16. ADDRESS<br><b>511 S. Hilton A</b>   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>  |   | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>N/A</b>   |  | 17. INFORMANT<br><b>Mr. Harry C. Meacham</b>  |   |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>cardiac arrest</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>coronary stenosis</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Approximate interval between onset and death: <b>years.</b> |   |   |  |   |   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |   |   |  |   |   |
| 19a. DATE OF OPERATION   |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |   |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |   | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)    |  |   |   |
| 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.          |   |   |  |   |   |
| 22b. SIGNATURE<br><b>MORTON MD</b>   |   | DEGREE  |  | 22c. DATE SIGNED<br><b>12/14/79</b>   |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |   | 22e. ADDRESS<br><b>22 S - Greene St. Balt. 21201</b>  |  | 22f. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |   |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |   | 23b. DATE<br><b>12/17/79</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Loudon Park Cemetery</b>   |   |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore City, Md.</b>   |   | 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>MacNabb Funeral Home Catonsville, Md.</b>  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>DEC 18 1979</b>   |   |
| 25b. REGISTRAR'S SIGNATURE<br><b>Patricia McLeod</b>   |   |   |  |   |   |

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  |   |   |  |  |  |  |
|--|--|---|--|---|---|--|--|--|--|
| 1. FOR<br>STATE<br>REGISTRAR   |  | 7 9 3 0 3 9 5<br>REG. NO.   |  |   |   |  |  |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><i>Howard James Meade</i>  |  |   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><i>12 18 79</i>              |  |  | 2b. HOUR<br><i>8:40 AM</i>   |  |
| 3. SEX<br><i>Male</i>  |  | 4. RACE<br><i>White</i>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><i>4 01 28</i>  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><i>51</i> YRS.  |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><i>Pennsylvania</i>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><i>USA</i>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><i>Baltimore City</i> MD.  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><i>Baltimore</i>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><i>Baltimore City Hospital</i> |  |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><i>Inspector</i>   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><i>G.M.</i>   |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  |   |  |   |   |  |  |  |  |
| 13a. STATE<br><i>Maryland</i>  |  | 13b. COUNTY<br><i>Baltimore</i>   |  | 13c. CITY OR TOWN<br><i>Fullerton</i>   |   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 13e. STREET ADDRESS<br><i>4546 Fitch Avenue</i>  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><i>Corey A Meade</i>   |  |   |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><i>Lydia Brown</i> |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><i>No</i>  |  | 16b. SOCIAL SECURITY NO.<br><i>206-26-1808</i>  |  | 17. INFORMANT<br>ADDRESS<br><i>Elizabeth H. Meade 4546 Fitch Avenue</i>   |   |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Cardiopulmonary arrest</i><br><i>4375</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |  |   |  |   |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |   |  |   |   |  |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><i>P.M. 19</i>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |   |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |   |  |   |   |  |  |  |  |
| 22b. SIGNATURE<br><i>D. Siegel M.D.</i>  |  |   |  |   |   | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br><i>12/18/79</i>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><i>D. Siegel</i>  |  |   |  | 22e. ADDRESS<br><i>Balt City Hospitals</i>  |   |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><i>Burial</i>   |  | 23b. DATE<br><i>12/22/79</i>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><i>Gardens of Faith</i>   |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><i>Overlea Baltimore Md.</i>   |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><i>Lassahn Funeral Home</i>  |  |   |  | ADDRESS<br><i>7401 Belair Road</i>  |   | 25a. DATE REC'D. BY REGISTRAR<br><i>DEC 20 1979</i>  |  | 25b. REGISTRAR'S SIGNATURE<br><i>Living</i>  |  |



2900

1971-1972



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING," IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |  |                         |  |  |  |   |  |   |  | REG. NO. 30396   |  |                                     |  |
|--|--|-------------------------|--|--|--|---|--|---|--|--|--|-------------------------------------|--|
| 1. DECEASED NAME (TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>HEATHER MARIE MEAGHER</b>  |  |                         |  |  |  |   |  |   |  | 2a. DATE OF DEATH<br>KNOWN <input checked="" type="checkbox"/> OF ESTI- MATED <input type="checkbox"/><br>MONTH DAY YEAR<br><b>12 26 19 79</b> |  | 7b. HOUR<br>M<br><b>2:00</b><br>P M |  |
| 3. SEX<br><b>female</b>  |  | 4. RACE<br><b>white</b> |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>5/6/75</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>4</b> YRS.                            |  | IF UNDER 1 YR. MONTHS DAYS<br>IF UNDER 24 HRS. HOURS MIN.   |  | 7c. DATE PRONOUNCED DEAD<br>MONTH DAY YEAR<br><b>12 26 19 79</b>   |  |                                     |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>   |  |                         |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  |   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.  |  |                                     |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |  |                         |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN BALTIMORE CITY, GIVE STREET ADDRESS)<br><b>Sinai Hospital</b> |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>None</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>None</b>   |  |                                     |  |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |                         |  |  |  |   |  |   |  |  |  |                                     |  |
| 13a. STATE<br><b>Maryland</b>  |  |                         |  | 13b. COUNTY  |  | 13c. CITY OR TOWN<br><b>Baltimore</b>                                       |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 13e. STREET ADDRESS<br><b>4112 Gladden Avenue</b>  |  |                                     |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Kevin James Meagher</b>   |  |                         |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Mary Elizabeth Keim</b> |  |   |  |  |  |                                     |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br><b>No</b>   |  |                         |  | 16b. SOCIAL SECURITY NO.<br><b>None</b>  |  | 17. INFORMANT<br>ADDRESS<br><b>William Meagher Balto., Md.</b>              |  |   |  |  |  |                                     |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1 DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Multiple visceral and skeletal injuries</b><br>Conditions, if any, which gave rise to immediate cause (a) stating the <u>under-lying</u> cause last.<br>(b) _____<br>(c) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>DUE TO, OR AS A CONSEQUENCE OF  |  |                         |  |  |  |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |                                     |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).  |  |                         |  |  |  |   |  |   |  |  |  |                                     |  |
| 19a. DATE OF OPERATION   |  |                         |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |  |   |  |   |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |                                     |  |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br><b>11:15 AM 12-26 1979</b>  |  |                         |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>11:15 AM 12-26 1979</b>  |  |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)<br><b>passenger in auto/bus collision</b>                                     |  |  |  |                                     |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>   |  |                         |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)<br><b>street</b>   |  |   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br><b>Belvedere &amp; Chinguapin Pkwy. Balto., Maryland</b>   |  |  |  |                                     |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . |  |                         |  |  |  |   |  |   |  |  |  |                                     |  |
| ACTUAL SIGNATURE<br><i>Virginia L. Dolan</i>   |  |                         |  | TITLE (SPECIFY)<br><b>Assistant</b>  |  |   |  | DATE SIGNED<br><b>12/27/79</b>  |  |  |  |                                     |  |
| EXAMINER'S NAME (TYPE OR PRINT)<br><b>Virginia L. Dolan, M.D.</b>  |  |                         |  | ADDRESS<br><b>111 Penn Street</b>  |  |   |  |   |  |  |  |                                     |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |  |                         |  | 23b. DATE<br><b>12/29/79</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Druid Ridge</b>                    |  |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Pikesville, Md.</b> |  |  |                                     |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Henry W. Jenkins &amp; Sons Co.</b>   |  |                         |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>DEC 31 1979</b>                         |  | 25b. REGISTRAR'S SIGNATURE<br><i>Henry W. Jenkins</i>   |  |  |  |                                     |  |
| ADDRESS<br><b>4905 York Road Balto., Md. 21212</b>   |  |                         |  |  |  |   |  |   |  |  |  |                                     |  |

00:00

5-28-51

85 22 25

1998 2000 2002

Page 100

000 000 000

potential for a 10% increase in the frequency of attacks.

1000000

100-12 000 177

... (a) ... (b) ... (c) ... (d) ... (e) ... (f) ... (g) ... (h) ... (i) ... (j) ... (k) ... (l) ... (m) ... (n) ... (o) ... (p) ... (q) ... (r) ... (s) ... (t) ... (u) ... (v) ... (w) ... (x) ... (y) ... (z) ...

1992

2

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 30397

|  |  |   |  |   |  |   |  |   |  |   |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |
|--|--|---|--|---|--|---|--|---|--|---|--|---|--|--|--|--|--|--|--|--|--|---|--|--|--|
| 1. FOR<br>STATE<br>REGISTRAR   |  | 2a. DECEASED NAME<br>(TYPE OR PRINT)              |  | FIRST<br>Mary   |  | MIDDLE<br>Elizabeth   |  | LAST<br>MEAGHER   |  | 2b. DATE KNOWN<br>OF<br>DEATH MATED   |  | MONTH<br>12   |  | DAY<br>26  |  | YEAR<br>1979   |  | 2c. HOUR<br>11:51                        |  |  |  |   |  |  |  |
| 3. SEX<br>female   |  | 4. RACE<br>white                                  |  | 5. DATE OF BIRTH<br>MONTH<br>2/10/56  |  | DAY<br>23   |  | YEAR<br>YRS.  |  | IF UNDER 1 YR.<br>MONTHS<br>DAYS  |  | IF UNDER 24 HRS.<br>HOURS<br>MIN.   |  | 2d. DATE<br>PRONOUNCED<br>DEAD   |  | MONTH<br>12  |  | DAY<br>26                                |  | YEAR<br>1979   |  | 2e. HOUR<br>a.m.  |  |  |  |
| 7a. BIRTHPLACE<br>(STATE OR<br>FOREIGN COUNTRY)  |  | 7b. CITIZEN OF WHAT COUNTRY?                      |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH  |  | 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)            |  | 12a. USUAL OCCUPATION (TYPE OF WORK<br>FOR MOST OF WORKING LIFE)  |  | 12b. KIND OF BUSINESS<br>OR INDUSTRY                                     |  | 13a. STATE<br>Maryland   |  | 13b. COUNTY                              |  | 13c. CITY OR TOWN<br>Baltimore   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br>4112 Gladden Avenue |  |
| 14. FATHER'S NAME<br>FIRST<br>Charles  |  | MIDDLE<br>Keim                                    |  | LAST<br>Mary  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST<br>Patricia   |  | MIDDLE<br>Jones   |  | LAST<br>Jones   |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)   |  | 16b. SOCIAL SECURITY NO.<br>217 48 5461                                  |  | 17. INFORMANT<br>William Meagher   |  | ADDRESS<br>Balto., Md.                   |  | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Multiple Injuries<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b)<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH   |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? |  | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input type="checkbox"/> OR<br>CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>11:15AM 12/26/79 |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)<br>driver of auto in collision with bus |  | 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/><br>AT WORK AT WORK |  | 21e. PLACE OF INJURY (AT HOME,<br>STREET, FACTORY, FARM, ETC.)<br>street |  | 21f. LOCATION<br>CITY OR TOWN<br>Belvedere Ave & Chinquapin Rd. Balto City, MD |  | 21g. LOCATION<br>COUNTY<br>BALTIMORE     |  | 21h. LOCATION<br>STATE<br>MD   |  |   |  |  |  |
| 22a. I certify that I took charge of the remains described above, held an<br>death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |  | 22b. TITLE (SPECIFY)<br>Assistant                 |  | 22c. MEDICAL EXAMINER<br>Hormez R. Guard, M.D.  |  | 22d. DATE<br>12/26/79   |  | 22e. ADDRESS<br>111 Penn Street, Balto., MD 21201                   |  | 22f. SIGNATURE<br>H.R. Guard  |  | 22g. DATE<br>12/26/79   |  | 22h. SIGNATURE<br>H.R. Guard   |  | 22i. DATE<br>12/26/79  |  | 22j. SIGNATURE<br>H.R. Guard             |  | 22k. DATE<br>12/26/79  |  | 22l. SIGNATURE<br>H.R. Guard  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial   |  | 23b. DATE<br>12/29/79                             |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Druid Ridge   |  | 23d. LOCATION<br>CITY OR TOWN<br>Pikesville, Md.  |  | 23e. LOCATION<br>COUNTY<br>BALTIMORE                                |  | 23f. LOCATION<br>STATE<br>MD  |  | 24. FUNERAL DIRECTOR<br>NAME<br>Henry W. Jenkins & Sons Co.   |  | 24b. ADDRESS<br>4905 York Road Balto., Md. 21212                         |  | 25a. DATE REC'D. BY REGISTRAR<br>DEC 31 1979                                   |  | 25b. REGISTRAR'S SIGNATURE<br>H.R. Guard |  | 25c. DATE<br>12/26/79  |  | 25d. SIGNATURE<br>H.R. Guard  |  |  |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |   |   |  |   |
|---|--|---|---|--|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Shannon Elizabeth Meagher</b>   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>Dec. 26, 1979</b>   |   | 2b. HOUR<br><b>12:26 PM</b>  |   |
| 3. SEX<br><b>Female</b>   | 4. RACE<br><b>White</b>  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Feb. 22, 1977</b>  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>2</b> YRS.   |   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City MD.</b>  |   |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>The Johns Hopkins Hospital</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>None</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>None</b>  |
| 13a. STATE<br><b>Maryland</b>   |  | 13b. COUNTY<br><b>Baltimore</b>   | 13c. CITY OR TOWN<br><b>Baltimore</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Kevin James Meagher</b>  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Mary Elizabeth Keim</b>   |   |  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>   |  | 16b. SOCIAL SECURITY NO<br><b>None</b>  |   | 17. INFORMANT<br>ADDRESS<br><b>William Meagher Balto., Md.</b>   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>compound depressed skull fracture</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Automobile accident</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b></b>  |  |   |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>640 minutes</b><br><b>640 minutes</b>        |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).  |  |   |   |  |   |
| 19a. DATE OF OPERATION<br><b>0</b>  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>0</b>  |   | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                     |   |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  |   |   |  |   |
| 21a. ACCIDENT WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>12:25 P.M. 12 26 1979</b>   |   | 21c. HOW INJURY OCCURRED<br>(ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)<br><b>auto hit bus</b> |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)<br><b>Street</b>   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br><b>Belvedere Ave Balto. City Md</b>                 |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>12/26</b> , 19 <b>79</b> , to <b>12/26</b> , 19 <b>79</b> , that (I) (we) lost saw the deceased alive on <b>12/26</b> , 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. |  |   |   |  |   |
| 22b. SIGNATURE<br><b>K. L. Lemoine</b>  |  | APPROVAL BY DR. DEGREE <b>GUARD, MED. EX. 1/8/80 kam</b>  |   |  | 22c. DATE SIGNED<br><b>12/26</b>  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>K. L. Lemoine</b>   |  | 22e. ADDRESS<br><b>Johns Hopkins Hospital</b>   |   |  |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>12/29/79</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Druid Ridge</b>   |   |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Pikesville, Md.</b>  |  |   |   |  |   |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Henry W. Jenkins &amp; Sons Co.</b>  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>DEC 31 1979</b>   |   | 25b. REGISTRAR'S SIGNATURE<br><b>Anthony McCreedy</b>  |   |
| 4905 York Road Balto., Md. 21212  |  |   |   |  |   |

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DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH7 9 3 0 3 9 9  
REG NO1- FOR  
STATE  
REGISTRAR1. DECEASED NAME  
(TYPE OR PRINT)

FIRST

MIDDLE

LAST

(MARTHA) MATTIE MEANS

2a. DATE OF DEATH

MONTH

DAY

YEAR

21 Dec 79

2b. HOUR

7 AM

3. SEX

F

4. RACE

B

5. DATE OF BIRTH

MONTH

DAY

YEAR

9 8 17

6. AGE (IN YEARS LAST BIRTHDAY)

62

IF UNDER 1 YEAR

MONTHS

DAYS

IF UNDER 74 HRS

HOURS

MIN.

7a. BIRTHPLACE  
(COUNTRY)

S.C.

7b. CITIZEN OF WHAT COUNTRY?

USA

8. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH

BALTO CITY

MD.

10. CITY OR TOWN OF DEATH

BALTO CITY

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION  
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)

MFL CHRONIC HOSP. BCH.

12a. USUAL OCCUPATION  
(TYPE OF WORK FOR MOST OF WORKING LIFE)

12b. KIND OF BUSINESS OR INDUSTRY

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE

MD

13b. COUNTY

13c. CITY OR TOWN

Balto.

13d. INSIDE CITY LIMITS?

YES ☒ NO ☐

13e. STREET ADDRESS

600 Pittsburgh Ave.

14. FATHER'S NAME

FIRST

MIDDLE

15. MOTHER'S MAIDEN NAME

FIRST

MIDDLE

LAST

Burnell

Sims

Emma

Brown

16a. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(YES, NO OR UNKNOWN)

No

16b. SOCIAL SECURITY NO.  
(IF YES, GIVE WAR OR DATES)

215-24-1917

17. INFORMANT

ADDRESS

Solomon Means 600 Pittsburgh Ave.

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  
PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

cardiorespiratory, arrest

4149  
Conditions, if any, which  
gave rise to immediate  
cause (a), stating the  
underlying cause last

DUE TO, OR AS A CONSEQUENCE OF

(b) Ischemic Heart Disease

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

34 mos.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

Gangrene R foot due to peripheral vascular disease.

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY?

YES ☐ NO ☐20b. IF YES, WERE FINDINGS USED  
IN CERTIFYING CAUSES OF DEATH?YES ☐ NO ☐21a. ACCIDENT WAS UNDERLYING ☐  
OR CONTRIBUTING ☐ CAUSE OF DEATH  
(IF EITHER, NOTIFY MEDICAL EXAMINER)21b. TIME OF INJURY  
HOUR A.M. MONTH DAY YEAR  
P.M. 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)

21d. INJURY OCCURRED

WHILE ☐ NOT WHILE ☐  
AT WORK AT WORK21e. PLACE OF INJURY  
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION

STREET

CITY OR TOWN

COUNTY

STATE

22a. I certify that (I) (this hospital) attended the deceased from \_\_\_\_\_, 19\_\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_\_, that (I) (we) last  
saw the deceased alive on \_\_\_\_\_, 19\_\_\_\_\_, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated  
above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE

DEGREE

ATTENDING  
PHYSICIAN ☐MEDICAL  
DIRECTOR ☒STAFF  
PHYSICIAN ☐

22c. DATE SIGNED

21 Dec 79

22d. PHYSICIAN'S NAME (TYPE OR PRINT)

22e. ADDRESS

23a. BURIAL, CREMATION, REMOVAL  
(SPECIFY)

Burial

23b. DATE

12/29/79

23c. NAME OF CEMETERY OR CREMATORY

Church Cem.

23d. LOCATION  
CITY OR TOWN

COUNTY

STATE

Fairfield Co., S.C.

24. FUNERAL DIRECTOR  
NAME

Wm C March F/H

ADDRESS

1101 E. North Ave.

25a. DATE REC'D. BY REGISTRAR

DEC 26 1979

25b. REGISTRAR'S SIGNATURE

L. H. H. H.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be detached for use as the burial-transit permit. Then please remove carbon copy. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1000

PARTIAL MEANS

BACTERIA

BACTERIA

Antibacterial

Antibacterial

Antibacterial

Antibacterial

Antibacterial



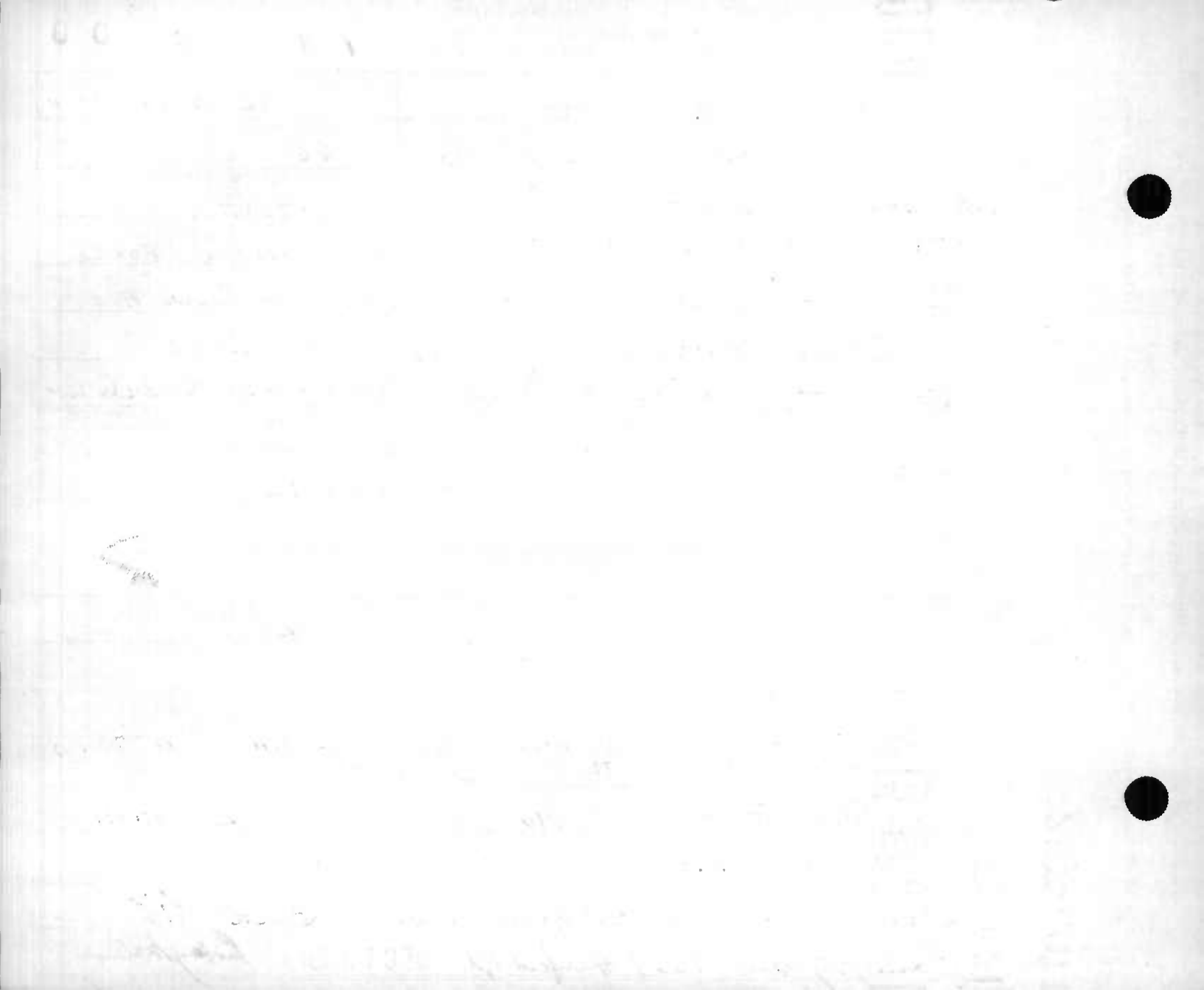
TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 1272000 after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

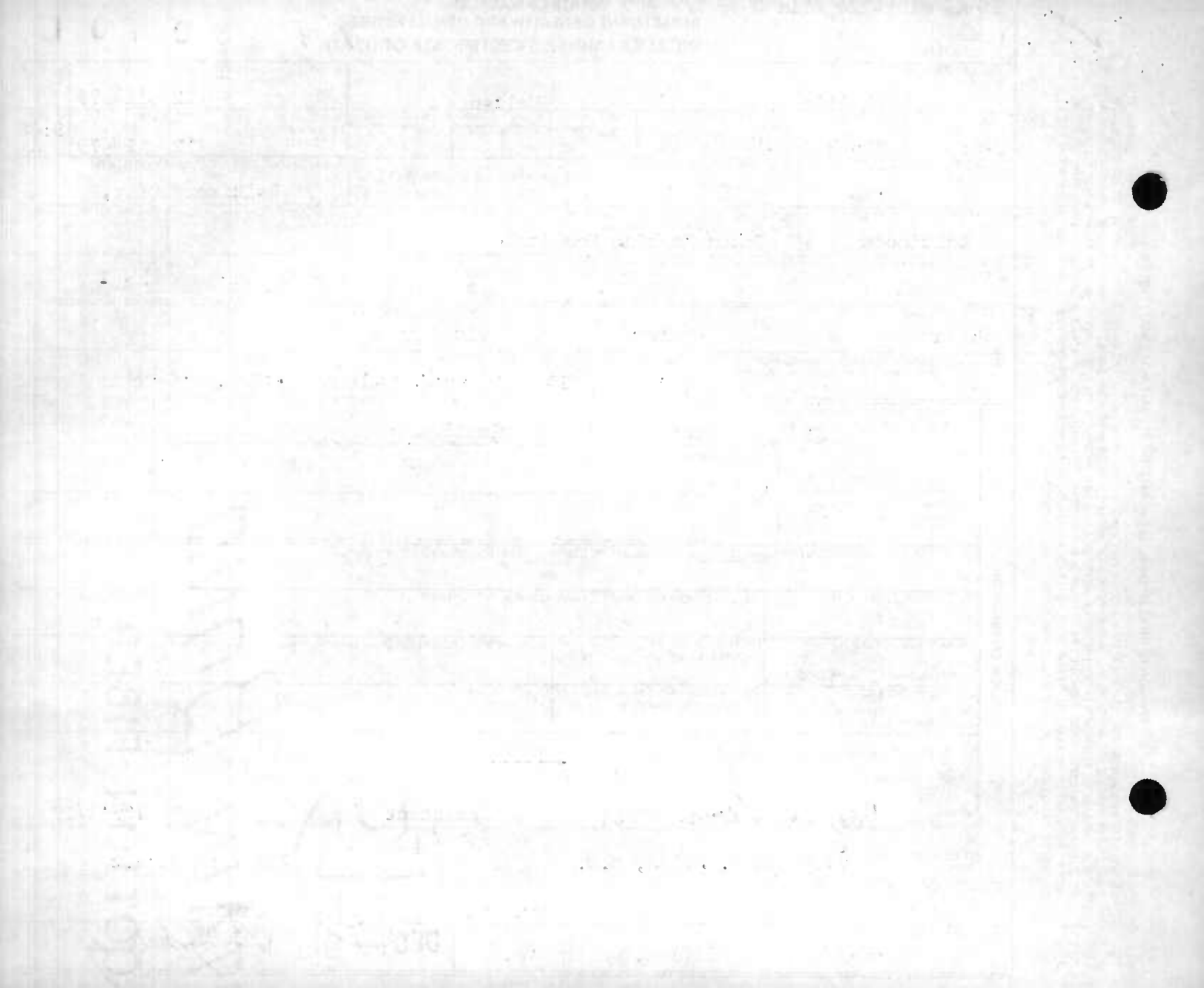
## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  |   |  |  |  |   |  |
|---|--|--|--|---|--|--|--|---|--|
| 1. FOR<br>STATE<br>REGISTRAR  |  | 7 9 3 0 4 0 0<br>REG. NO.  |  | 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>CATHERINE M. MELSE  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>12 10 79                                      |  | 2b. HOUR<br>330 P.M.  |  |
| 3. SEX<br>F   |  | 4. RACE<br>W   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>12-7-1913   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>66 YRS  |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>MARYLAND   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U. S. A.   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD.                           |  |   |  |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>UNION MEMORIAL HOSPITAL |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>PRESS OPERATOR   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Box Co.  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE MD. 13b. COUNTY - 13c. CITY OR TOWN BALTO.   |  |  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 13e. STREET ADDRESS<br>4203 LA SALLE AVE.  |  |   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>CASPER FALKENHAN  |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>KATIE MAY DAVIS  |  |  |  |   |  |
| 16a. WAS DECEASED EVER IN U. S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>NO   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>218-03-6706   |  | 17. INFORMANT<br>ADDRESS<br>John W. Meise - 4203 La Salle Ave.  |  |  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) CVA<br>1830<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) Metastatic ovarian Ca.<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |  |  |   |  |  |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |  |  |   |  |  |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |   |  |
| 22a. I certify that (if this hospital) attended the deceased from 11/27, 19 79, to 12/10, 19 79, that (I) (we) last saw the deceased alive on 12/10, 19 79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) (did) (did not) view the body after death.                                |  |  |  |   |  |  |  |   |  |
| 22b. SIGNATURE<br>Alan Gaby   |  |  |  | DEGREE<br>MD  |  |  |  | 22c. DATE SIGNED<br>12/10/79  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>ALAN GABY M.D.   |  |  |  | 22e. ADDRESS<br>UNION MEMORIAL HOSPITAL   |  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>BURIAL  |  | 23b. DATE<br>12-14-79  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>HOLY REDEEMER CEM.  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>BALTO. MD.                             |  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Dorothy Miller - 7527 Harford Rd.   |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br>DEC 13 1979  |  | 25b. REGISTRAR'S SIGNATURE<br>Dorothy Miller   |  |   |  |



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, THE MEDICAL EXAMINER SHOULD EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR FOR PAGES 4, 5, AND 6. GIVE PAGES 7, 8, AND 9 TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR THE FUNERAL DIRECTOR. PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| Items #18a-22a Film 0539 1/25/80 r STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH   |  |         |  |   |  |                                    |  |  |  |                  |  | REG. NO. 30401  |  |  |  |   |  |
|--|--|---------|--|---|--|------------------------------------|--|--|--|------------------|--|---|--|--|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT)   |  |         |  |   |  | FIRST                              |  | MIDDLE   |  | LAST             |  | 2a. DATE KNOWN OF DEATH   |  | <input checked="" type="checkbox"/> MONTH<br><input type="checkbox"/> DAY<br><input type="checkbox"/> YEAR |  | 2b. HOUR  |  |
| Phyllis  |  |         |  |   |  | V.                                 |  | Melton   |  |                  |  | 12 11 79  |  | M  |  |   |  |
| 3. SEX   |  | 4. RACE |  | 5. DATE OF BIRTH  |  | 6. AGE (IN YEARS)                  |  | IF UNDER 1 YR.   |  | IF UNDER 24 HRS. |  | 7c. DATE PRONOUNCED DEAD  |  | 7d. HOUR   |  |   |  |
| Female   |  | Black   |  | 10 25 52  |  | 27 YRS.                            |  |  |  |                  |  | 12 11 79  |  | 9:48 AM  |  |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  |         |  | 7b. CITIZEN OF WHAT COUNTRY?  |  |                                    |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |                  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |  |  |  |   |  |
| Md.  |  |         |  | USA   |  |                                    |  |  |  |                  |  | Baltimore City, MD  |  |  |  |   |  |
| 10. CITY OR TOWN OF DEATH  |  |         |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |                                    |  |  |  |                  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)       |  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY                                   |  |
| Baltimore  |  |         |  | Johns Hopkins Hospital  |  |                                    |  |  |  |                  |  |   |  |  |  |   |  |
| 13a. STATE   |  |         |  | 13b. COUNTY   |  |                                    |  | 13c. CITY OR TOWN  |  |                  |  | 13d. INSIDE CITY LIMITS?  |  | 13e. STREET ADDRESS  |  |   |  |
| Md.  |  |         |  |   |  |                                    |  | Balto.   |  |                  |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 1918 E. Lafayette Ave.   |  |   |  |
| 14. FATHER'S NAME  |  |         |  |   |  | 15. MOTHER'S MAIDEN NAME           |  |  |  |                  |  |   |  |  |  |   |  |
| Robert   |  |         |  |   |  | Melton                             |  |  |  |                  |  | Virginia  |  |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)   |  |         |  |   |  | 16b. SOCIAL SECURITY NO.           |  |  |  |                  |  | 17. INFORMANT ADDRESS   |  |  |  |   |  |
| No   |  |         |  |   |  | 219-56-6434                        |  |  |  |                  |  | Virginia Melton 1918 E. Lafayette Avenue                            |  |  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |  |         |  |   |  |                                    |  |  |  |                  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |   |  |
| PART I DEATH WAS CAUSED BY:  |  |         |  |   |  |                                    |  |  |  |                  |  |   |  |  |  |   |  |
| IMMEDIATE CAUSE (a) <u>Acute heroin intoxication</u>   |  |         |  |   |  |                                    |  |  |  |                  |  |   |  |  |  |   |  |
| DUE TO, OR AS A CONSEQUENCE OF   |  |         |  |   |  |                                    |  |  |  |                  |  |   |  |  |  |   |  |
| Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.  |  |         |  |   |  |                                    |  |  |  |                  |  |   |  |  |  |   |  |
| (b)  |  |         |  |   |  |                                    |  |  |  |                  |  |   |  |  |  |   |  |
| DUE TO, OR AS A CONSEQUENCE OF   |  |         |  |   |  |                                    |  |  |  |                  |  |   |  |  |  |   |  |
| (c)  |  |         |  |   |  |                                    |  |  |  |                  |  |   |  |  |  |   |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).  |  |         |  |   |  |                                    |  |  |  |                  |  |   |  |  |  |   |  |
| 19a. DATE OF OPERATION   |  |         |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |  |                                    |  |  |  |                  |  |   |  |  |  | 20. AUTOPSY?  |  |
|  |  |         |  |   |  |                                    |  |  |  |                  |  |   |  |  |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |  |         |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR  |  |                                    |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)  |  |                  |  |   |  |  |  |   |  |
|  |  |         |  | P.M. 19   |  |                                    |  |  |  |                  |  |   |  |  |  |   |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |         |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)   |  |                                    |  | 21f. LOCATION  |  |                  |  |   |  |  |  |   |  |
|  |  |         |  |   |  |                                    |  | STREET CITY OR TOWN COUNTY STATE   |  |                  |  |   |  |  |  |   |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |  |         |  |   |  |                                    |  |  |  |                  |  |   |  |  |  |   |  |
| ACTUAL SIGNATURE   |  |         |  | TITLE (SPECIFY)   |  |                                    |  | DATE SIGNED  |  |                  |  |   |  |  |  |   |  |
| Virginia L. Dolan  |  |         |  | Assistant   |  |                                    |  | 12/11/79   |  |                  |  |   |  |  |  |   |  |
| EXAMINER'S NAME (TYPE OR PRINT)  |  |         |  | ADDRESS   |  |                                    |  |  |  |                  |  |   |  |  |  |   |  |
| Virginia L. Dolan, M.D.  |  |         |  | 111 Penn Street   |  |                                    |  |  |  |                  |  |   |  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |  |         |  | 23b. DATE   |  | 23c. NAME OF CEMETERY OR CREMATORY |  |  |  | 23d. LOCATION    |  |   |  |  |  |   |  |
| Burial   |  |         |  | 12/15/79  |  | Arbutus Mem. Pk.                   |  |  |  | Arbutus, Md.     |  |   |  |  |  |   |  |
| 24. FUNERAL DIRECTOR   |  |         |  | 25. DATE REC'D. BY REGISTRAR  |  |                                    |  | 25b. REGISTRAR'S SIGNATURE   |  |                  |  |   |  |  |  |   |  |
| Wm C March F/H   |  |         |  | 1101 E. North Ave.  |  |                                    |  | DEC 13 1979  |  |                  |  | [Signature]   |  |  |  |   |  |





STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO. 7 9 3 0 4 0 2

1. FOR  
STATE  
REGISTRAR

|  |  |   |   |   |
|--|--|---|---|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Gordon L. Melvin                    |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>December 11 1979   |   | 2b. HOUR<br>M   |
| 3. SEX<br>Male   | 4. RACE<br>White   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>July 6 1909   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>70<br>YRS  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Md.                           | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City<br>MD.                                   |
| 10. CITY OR TOWN OF DEATH<br>Balto.  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>3208 Brendan Avenue |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>self-employed | 12b. KIND OF BUSINESS OR INDUSTRY<br>Home Imprvmt   |
| 13a. STATE<br>Md.  |  | 13b. COUNTY   | 13c. CITY OR TOWN<br>Balto.   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>unknown                          |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Daisy  |   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>no |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>218-01-6605  |   | 17. INFORMANT<br>ADDRESS<br>same address<br>Catherine Melvin (wife)                             |

|   |  |  |
|---|--|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarction</u><br>410 -<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br><u>1 hr immediate</u> |
|---|--|--|

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c)

|  |  |  |   |
|--|--|--|---|
| 19a. DATE OF OPERATION   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>May 9, 1967</u> to <u>present</u> 12-12-79, that (I) (we) last saw the deceased alive on <u>9-28-79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |   |
| 22b. SIGNATURE<br><i>George Roveti</i>   |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | 22c. DATE SIGNED<br>12-13-79  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Dr. George Roveti   |  | 22e. ADDRESS<br>100 N. Broadway  |   |

|  |                       |   |  |
|--|-----------------------|---|--|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial | 23b. DATE<br>12/15/79 | 23c. NAME OF CEMETERY OR CREMATORY<br>Loudon Park | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Balto. Md. |
| 24. FUNERAL DIRECTOR<br>Schumnek Funeral Home, Inc.    |                       | 25a. DATE REC'D. BY REGISTRAR<br>DEC 18 1979      | 25b. REGISTRAR'S SIGNATURE<br><i>Barbara McCreedy</i>    |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified by report.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  |  |   |  |                                       |  |   | 7 9 3 0 4 0 3<br>REG. NO.  |   |                                     |   |                           |  |
|--|--|--|--|--|---|--|---------------------------------------|--|---|--|---|-------------------------------------|---|---------------------------|--|
| 1- FOR STATE REGISTRAR   |  |  |  |  | 1. DECEASED NAME<br>FIRST MIDDLE LAST<br><b>SANDRA MELVIN</b>           |  |                                       |  |   | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>DECEMBER 24 1979</b>  |   |                                     |   | 2b. HOUR<br><b>11:20P</b> |  |
| 3 SEX<br><b>Female</b>   |  |  | 4 RACE<br><b>Black</b>   |  | 5 DATE OF BIRTH<br>MONTH DAY YEAR<br><b>8 1 55</b>                      |  |                                       | 6 AGE (IN YEARS LAST BIRTHDAY)<br><b>24</b> YRS.                                     |   |  | 7a. UNDER 1 YEAR<br>MONTHS DAYS<br><b>0 0</b>     |                                     | 7b. UNDER 24 HRS<br>HOURS MIN<br><b>0 0</b> |                           |  |
| 7c. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>N.C.</b>   |  |  | 7d. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  |   | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                       |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.                                |  |   |                                     |   |                           |  |
| 10 CITY OR TOWN OF DEATH<br><b>Baltimore</b>   |  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>JOHNS HOPKINS HOSPITAL</b> |  |   |  |                                       | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)                     |   |  | 12b. KIND OF BUSINESS OR INDUSTRY                 |                                     |   |                           |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>Maryland</b>  |  |  |  |  | 13b. COUNTY   |  | 13c. CITY OR TOWN<br><b>Baltimore</b> |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>2534 E. Hoffman St.</b> |                                     |   |                           |  |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>JIM MELVIN</b>   |  |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>LUCILLE ELLIOTT</b> |  |                                       |  |   |  |   |                                     |   |                           |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>  |  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>220-64-0504</b>  |  | 17 INFORMANT<br><b>LUCILLE MELVIN</b>                                   |  |                                       |  |   | ADDRESS<br><b>2534 E. Hoffman St.</b>  |   |                                     |   |                           |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <b>Asystole</b><br><b>4539</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Probable Pulmonary Embolus</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Possible Deep Venous Thrombosis</b> |  |  |  |  |   |  |                                       |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>2 hrs</b><br><b>2 hrs</b><br><b>3 days</b>  |   |                                     |   |                           |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |  |  |  |   |  |                                       |  |   |  |   |                                     |   |                           |  |
| 19a. DATE OF OPERATION   |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   |  |                                       | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                 |   |                                     |   |                           |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |                                       |  |   |  |   |                                     |   |                           |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |                                       |  |   |  |   |                                     |   |                           |  |
| 22a. I certify that (1) (this hospital) attended the deceased from <b>24 December, 19 79</b> , to <b>24 December, 19 79</b> , that (1) (we) last saw the deceased alive on <b>24 December, 19 79</b> , and that (1) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did) (did not) view the body after death.  |  |  |  |  |   |  |                                       |  |   |  |   |                                     |   |                           |  |
| 22b. SIGNATURE<br><b>James W. Hathorn</b>  |  |  |  |  | DEGREE<br><b>MD.</b>  |  |                                       |  |   | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |   | 22c. DATE SIGNED<br><b>12/24/79</b> |   |                           |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>JAMES W. HATHORN, MD.</b>  |  |  |  |  | 22e. ADDRESS<br><b>Johns Hopkins Hospital</b>                           |  |                                       |  |   |  |   |                                     |   |                           |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>SPECIFY<br><b>Burial</b>  |  |  | 23b. DATE<br><b>12-29-79</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>MT. CALVARY CEM.</b>           |  |                                       | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>ANNE ARUNDEL CO., MD.</b>           |   |  |   |                                     |   |                           |  |
| 24 FUNERAL DIRECTOR<br>NAME<br><b>Wm. C. March F/H</b>   |  |  |  |  | ADDRESS<br><b>1101 E. North Ave.</b>                                    |  |                                       | 25a. DATE REC'D. BY REGISTRAR<br><b>DEC 28 1979</b>                                  |   | 25b. REGISTRAR'S SIGNATURE<br><b>Robert McCreedy</b>   |   |                                     |   |                           |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH-16 25M  
(VRA 15, 4) 1/79

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  | 7 9 3 0 4 0 4<br>REG. NO.   |  |   |  |                         |
|---|--|--|--|---|--|---|--|-------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>WILLIAM GEARY MELVIN</b>   |  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR <b>12 27 79</b>  |  |   |  | 2b. HOUR <b>6:50 PM</b> |
| 3. SEX <b>Male</b>  |  | 4. RACE <b>White</b>   |  | 5. DATE OF BIRTH MONTH DAY YEAR <b>May 14,</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY) <b>61</b> YRS.  |  |                         |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Balto. Maryland</b>  |  | 7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY MD.</b>  |  |                         |
| 10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>ST. AGNES HOSPITAL</b> |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Salesman Liquors</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |                         |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE <b>Maryland</b> 13b. COUNTY <b>Howard</b> 13c. CITY OR TOWN <b>Ellicott City</b>  |  |  |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 13e. STREET ADDRESS <b>3722 Ligon Road 21043</b>  |  |                         |
| 14. FATHER'S NAME FIRST MIDDLE LAST <b>late William Melvin</b>  |  |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Lillian (Geary)</b>   |  |   |  |                         |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b>  |  | 16b. SOCIAL SECURITY NO <b>WW 11 216 05 3469</b>   |  | 17. INFORMANT ADDRESS <b>Mrs Catherine Melvin 3742 Ligon Rd 21043</b>   |  |   |  |                         |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Acute Anteroseptal Infarction</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>Old Inferior Myocardial Infarction</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>Atherosclerotic Heart Disease</b> |  |  |  |   |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |                         |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)   |  |  |  |   |  |   |  |                         |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |                         |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>12-23-79</b> P.M. <b>19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |                         |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION CITY OR TOWN COUNTY STATE   |  |   |  |                         |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>12-23-79</b> to <b>12-27-79</b> , that (I) (we) last saw the deceased alive on <b>12-27-79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |   |  |   |  |                         |
| 22b. SIGNATURE <b>C. K. MALHOTRA</b> DEGREE <b>M.D.</b>   |  |  |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>       |  | 22c. DATE SIGNED <b>12-27-79</b>  |  |                         |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>C. K. MALHOTRA</b>   |  |  |  | 22e. ADDRESS <b>900 CATON AVE. BALTIMORE, MD. 21229</b>   |  |   |  |                         |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>   |  | 23b. DATE <b>Dec. 31, 1979</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY <b>Loudon Park</b>   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore, Maryland</b>  |  |                         |
| 24. FUNERAL DIRECTOR <b>Harry H. Fitzke</b> ADDRESS <b>4112 Columbia Rd Ellicott City</b>   |  |  |  | 25a. DATE REC'D. BY REGISTRAR <b>DEC 31 1979</b>  |  | 25b. REGISTRAR'S SIGNATURE <b>Patricia McCreedy</b>   |  |                         |

BP.

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BALTIMORE CITY

ST. AGNES HOSPITAL

BALTIMORE

3720 TOWN ROAD CLINIC

Face of patient

( )

600 CATON AVE. BALTIMORE, MD. 21206

NO. 11, NOV. 1966

THIS IS A COPY OF THE ORIGINAL RECORD

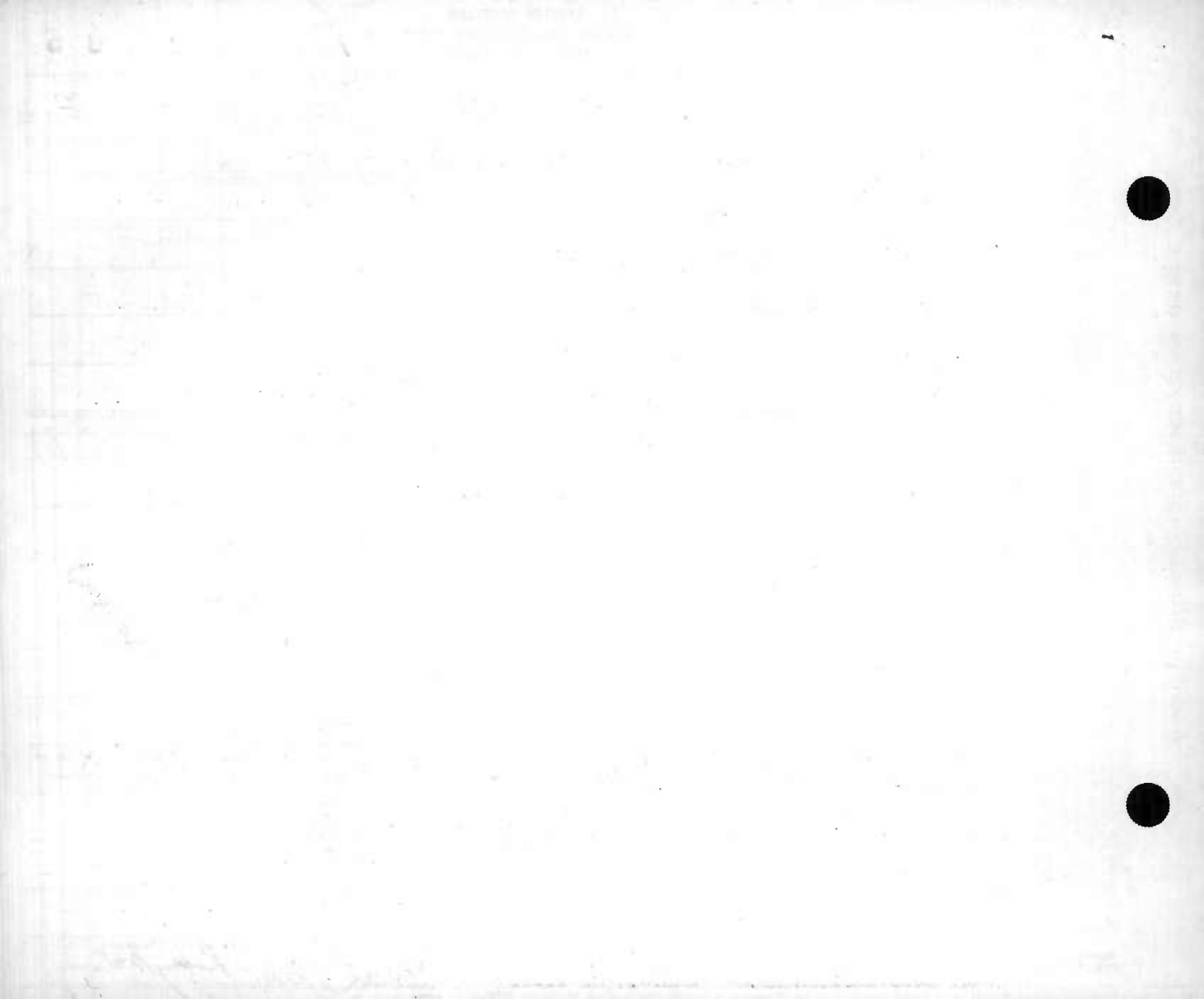
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  | 7 9 3 0 4 0 5<br>REG. NO.   |  |  |  |   |  |
|---|--|--|--|---|--|--|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT)<br>HARRY B. MENDELSON  |  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br>12/31/79  |  |  |  | 2b. HOUR<br>5:30 AM                           |  |
| 3. SEX<br>MALE  |  | 4. RACE<br>CAUCASIAN   |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>01-26-1906   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>73 YRS  |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>BALTO, MD  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD.   |  |   |  |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>LEVINDALE GERIATRIC CNTR |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>SALESMAN   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>RETAIL  |  |   |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>MD  |  | 13b. COUNTY<br>BALTO   |  | 13c. CITY OR TOWN<br>BALTI  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |  | 13e. STREET ADDRESS<br>5610 BLAND AVE. #21215 |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>SOLOMON MENDELSON  |  |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>SARAH UNKNOWN   |  |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>NO   |  | 16b. SOCIAL SECURITY NO.<br>215-12-1989  |  | 17. INFORMANT MR. WILLIAM MENDELSON<br>103 CHARGEUR RD., REISTERSTOWN, MD 21136   |  |  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Acute Myocardial infarction (most probable)</u><br>410-<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Hyper-tensive cardio-vascular disease</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>Arteriosclerotic Heart disease</u>  |  |  |  |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):<br><u>Congenital hydrocephalus, paraplegia, Anemia</u>   |  |  |  |   |  |  |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |   |  |
| 21d. INJURY OCCURRED<br>WRITE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |   |  |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>8/10/79</u> to <u>12/31/79</u> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>5:30 AM 12/31/79</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above <input checked="" type="checkbox"/> (we) (did) (did not) view the body after death. |  |  |  |   |  |  |  |   |  |
| 22b. SIGNATURE<br><u>[Signature]</u>  |  |  |  | DEGREE<br>MD. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>    |  |  |  | 22c. DATE SIGNED<br>12/31/79                  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>KHIN-M. TUN  |  |  |  | 22e. ADDRESS<br>2110 Pot Spring Road, Balto Md 21093  |  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>BURIAL   |  | 23b. DATE<br>JAN. 2, 1980  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>BETH JACOB ANSHE VESHEAR  |  | 23d. LOCATION<br>ROSEDALE BALTO. MD  |  |   |  |
| 24. FUNERAL DIRECTOR SOL LEVINSON & BROS., INC.<br>NAME ADDRESS   |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br>JAN 3 1980   |  | 25b. REGISTRAR'S SIGNATURE<br><u>[Signature]</u>   |  |   |  |
| 6010 REISTERSTOWN RD. BALTO., MD 21215  |  |  |  |   |  |  |  |   |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must post final cause.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  |  |  |  |  |   |  | 7 9 3 0 4 0 6<br>REG. NO.  |  |
|---|--|---|--|--|--|--|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Debra BERGER Menaker</b>  |  |   |  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>December 9, 1979</b>   |  |   | 2b. HOUR<br><b>10:05a M</b>                          |  |  |
| 3 SEX<br><b>FEMALE</b>  |  | 4 RACE<br><b>WHITE</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>MAR. 9, 1937</b>  |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br><b>42</b> YRS.   |  | 7 UNDER 1 YEAR<br>MONTHS DAYS<br><b>12 9</b>  |  | 7 UNDER 24 HRS<br>HOURS MIN<br><b>10 05</b>  |  |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MARYLAND</b>   |  | 7b CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD  |  |   |  |  |  |
| 10 CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Maryland General Hospital</b> |  |  |  | 12a USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>TEACHER</b>  |  |   | 12b KIND OF BUSINESS OR INDUSTRY<br><b>EDUCATION</b> |  |  |
| 13a STATE<br><b>MARYLAND</b>  |  |   |  |  |  | 13b COUNTY<br><b>HOWARD</b>  |  | 13c CITY OR TOWN<br><b>COLUMBIA</b>   |  | 13d INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>HERBERT BERGER</b>  |  |   |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>BETTY ZISKIN</b>   |  |   |  |  |  |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>  |  | 16b SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>213-34-8520</b>  |  | 17 INFORMANT <b>MR. TERRY BERGER</b><br><b>10206 LORAIN AVE., SILVER SPRING, MD 20901</b>  |  |  |  |   |  |  |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1 DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Metastatic Disease from Breast Cancer</b><br><b>1749</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last   |  |   |  |  |  |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>3 years</b>                                 |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |   |  |  |  |  |  |   |  |  |  |
| 19a DATE OF OPERATION<br><b>1976</b>  |  | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>Right Mastectomy for Breast Carcinoma</b>   |  |  |  | 20a AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |  |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. <b>19</b>  |  | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |   |  |  |  |
| 21d INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |   |  |  |  |
| 22a I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>11/28/</b> <b>19</b> <b>79</b> , to <b>12/9/</b> <b>19</b> <b>79</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>12/9/</b> <b>19</b> <b>79</b> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) (did) (not) view the body after death. |  |   |  |  |  |  |  |   |  |  |  |
| 22b SIGNATURE<br><b>Kai-Fu Chow</b>   |  |   |  |  |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c DATE SIGNED<br><b>12/9/79</b>   |  |  |  |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Kai-Fu Chow, M.D.</b>  |  |   |  |  |  | 22e ADDRESS<br><b>c/o 827 Linden Ave. Balto. MD 21201</b>  |  |   |  |  |  |
| 23a BURIAL, CREMATION, REMOVAL (SPEC)<br><b>BURIAL</b>  |  | 23b DATE<br><b>DEC.10,1979</b>  |  | 23c NAME OF CEMETERY OR CREMATORY<br><b>PROG. RUDOMER RUSS VREIN</b>   |  | 23d LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>ROSEDALE BALTO. MD</b>   |  |   |  |  |  |
| 24 FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>SOL LEVINSON &amp; BROS., INC.<br/>6010 REISTERSTOWN RD. BALTO., MD 21215</b>   |  |   |  |  |  | 25a DATE REC'D. BY REGISTRAR<br><b>DEC 13 1979</b>   |  | 25b REGISTRAR'S SIGNATURE<br><b>Ruby McHenry</b>  |  |  |  |

0 0 0 0 0 0 0 0 0 0

10-034

December 9, 1975

Memorandum

10-14

Baltimore City

Maryland General Hospital

Baltimore

3 years

Neoplastic Disease from Breast Cancer

Right Mastectomy for Breast  
Carcinoma

1975

x

79 - x

12/21/75

79

11/28/75

xx

79

12/21/75

x

xxx

x

401-711 Broadway Ave. Baltimore, MD 21201

401-711 Broadway Ave.

DEC 18 1975

*Handwritten signature*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  |  |  |  |  |   |  | REG. NO. 7 9 3 0 4 0 7   |  |  |  |
|---|--|--|--|--|--|--|--|---|--|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>MARY LOUISE MERCURIO</b>   |  |  |  |  |  | 2a. DATE OF DEATH<br>MONTH <b>12</b> DAY <b>27</b> YEAR <b>79</b>  |  |   |  | 2b. HOUR<br><b>1:35</b> AM   |  |  |  |
| 3 SEX<br><b>Female</b>  |  | 4 RACE<br><b>White</b>   |  | 5 DATE OF BIRTH<br>MONTH <b>5</b> DAY <b>24</b> YEAR <b>11</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>68</b> YRS.  |  | IF UNDER 1 YEAR<br>MONTHS <b></b> DAYS <b></b>  |  | IF UNDER 24 HRS<br>HOURS <b></b> MIN. <b></b>  |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.  |  |   |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>St. Agnes Hospital</b> |  |  |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Housewife</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Own Home</b>  |  |  |  |  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |  |  |  |  | 13a. STATE<br><b>Md</b>  |  | 13b. COUNTY<br><b>Baltimore</b>   |  | 13c. CITY OR TOWN<br><b>Catonsville</b>  |  |  |  |
| 14. FATHER'S NAME<br>FIRST <b>Antonio</b> MIDDLE <b></b> LAST <b>Porreco</b>  |  |  |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>Rose</b> MIDDLE <b></b> LAST <b>Miller</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>   |  |  |  |  |  | 16b. SOCIAL SECURITY NO.<br><b>215-40-4678</b>   |  | 17. INFORMANT<br><b>Mario Mercurio</b> ADDRESS<br><b>Same as #13</b>                            |  |  |  |  |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br><b>4340</b> IMMEDIATE CAUSE (a) <b>RESPIRATORY ARREST</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>CEREBRAL THROMBOSIS</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b></b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |  |  |  |  |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |  |  |  |  |  |  |   |  |  |  |  |  |
| 19a. DATE OF OPERATION  |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |   |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |   |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>12/25/1979</b> to <b>12/27/1979</b> , that (I) (we) last saw the deceased alive on <b>19</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.   |  |  |  |  |  |  |  |   |  |  |  |  |  |
| 22b. SIGNATURE<br><b>H. S. Ahluwalia</b>  |  |  |  |  |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br><b>12/27/79</b>   |  |  |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>H. S. AHLUWALIA</b>   |  |  |  |  |  | 22e. ADDRESS<br><b>900 CATON AVE. BALT. MD. 21208</b>  |  |   |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>12/29/79</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Lakeview</b>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Sykesville Carroll Md</b>   |  |   |  |  |  |  |  |
| 24 FUNERAL DIRECTOR<br>NAME <b>Witzke Funeral Home</b> ADDRESS <b>of Catonsville</b>  |  |  |  |  |  | 25a. DATE RECEIVED BY REGISTRAR <b>DEC 31 1979</b> 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>  |  |   |  |  |  |  |  |
| 1630 Edmondson Avenue Catonsville, Maryland   |  |  |  |  |  |  |  |   |  |  |  |  |  |

ST. LOUIS, MO.



ST. LOUIS, MO.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  |  |  |   |  |  |  |
|---|--|--|--|--|--|---|--|--|--|
| 1. FOR STATE REGISTRAR  |  | 7 9 3 0 4 0 8  |  | REG. NO.   |  |   |  |  |  |
| 1. DECEASED NAME (TYPE OR PRINT)  |  | FIRST  |  | MIDDLE   |  | LAST  |  | 2a. DATE OF DEATH MONTH DAY YEAR             |  |
| Josephine   |  |  |  |  |  | Messina   |  | 12-26-79                                     |  |
| 3. SEX  |  | 4. RACE  |  | 5. DATE OF BIRTH MONTH DAY YEAR  |  | 6. AGE (IN YEARS LAST BIRTHDAY)   |  | 7b. HOUR                                     |  |
| F   |  | Cauc   |  | 11 8 91  |  | 88 YRS.   |  | 6:25 AM                                      |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH  |  |  |  |
| Italy   |  | USA  |  |  |  | BALTIMORE CITY  |  | MD.  |  |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |  |  |
| BALTIMORE   |  | ST AGNES Hosp  |  | Homemaker  |  | Own Home  |  |  |  |
| 13a. STATE  |  | 13b. COUNTY  |  | 13c. CITY OR TOWN  |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                            |  | 13e. STREET ADDRESS                          |  |
| Md  |  | Baltimore  |  | Woodlawn   |  |   |  | 5712 Johnnycake Road                         |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST   |  | 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)   |  | 16b. SOCIAL SECURITY NO.  |  | 17. INFORMANT ADDRESS                        |  |
| Vincent   |  | Maranto  |  | Dorothy  |  | Saia  |  | Marie M. Grad                                |  |
| no  |  | 213-74-5481  |  | 2240 Lake Drive Pasadena, Md. 21122  |  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <u>ACUTE CARDIO-RESPIRATORY FAILURE</u><br>5849<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>AC. RENAL FAILURE, SEPTICAEMIA</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____                         |  |  |  |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____  |  |  |  |  |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |   |  |  |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>12-25-1979</u> to <u>12-26-1979</u> , that (I) (we) lost saw the deceased alive on <u>12-25-1979</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |   |  |  |  |
| 22b. SIGNATURE  |  | DEGREE   |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                          |  | 22c. DATE SIGNED  |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  | 22e. ADDRESS   |  |  |  |   |  |  |  |
| Dr. Desai   |  |  |  |  |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE   |  |  |  |
| Burial  |  | 12/29/79   |  | New Cathedral Cemetery   |  | Baltimore Maryland  |  |  |  |
| 24. FUNERAL DIRECTOR NAME   |  | 24b. ADDRESS   |  | 25a. DATE REC'D BY REGISTRAR   |  | 25b. SIGNATURE  |  |  |  |
| Witzke Funeral Home of Catonsville  |  | 1630 Edmondson Avenue Catonsville, Md. 21228   |  | DEC 26 1979  |  |   |  |  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  |   |  |   |  |                     |  |   |  |           |  |
|---|--|---|--|---|--|---|--|---------------------|--|---|--|-----------|--|
| 1. FOR<br>STATE<br>REGISTRAR  |  | 7 9 3 0 4 0 9<br>REG. NO.   |  |   |  |   |  |                     |  |   |  |           |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |  |   |  | 2a. DATE OF DEATH   |  | MONTH   |  | DAY                 |  | YEAR  |  | 2b. HOUR  |  |
| HELEN MARIE MICHALIODIS   |  |   |  | 12/5/79   |  | 12  |  | M                   |  |   |  |           |  |
| 3. SEX  |  | 4. RACE   |  | 5. DATE OF BIRTH  |  | 6. AGE (IN YEARS LAST BIRTHDAY)                                     |  | IF UNDER 1 YEAR     |  | IF UNDER 24 HRS                                 |  |           |  |
| FEMALE  |  | WHITE   |  | 2 10 12   |  | 67 YRS.   |  | MONTHS              |  | DAYS  |  | HOURS MIN |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  | 7b. CITIZEN OF WHAT COUNTRY?  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |  |                     |  |   |  |           |  |
| New Jersey  |  | USA   |  |   |  | BALTIMORE CITY MD.  |  |                     |  |   |  |           |  |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)  |  | 12b. KIND OF BUSINESS OR INDUSTRY                                   |  |                     |  |   |  |           |  |
| BALTO.  |  | U of Md 22 S. Greenest  |  | Housewife   |  | Homemaking  |  |                     |  |   |  |           |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  | 13b. COUNTY   |  | 13c. CITY OR TOWN   |  | 13d. INSIDE CITY LIMITS?  |  | 13e. STREET ADDRESS |  |   |  |           |  |
| MD  |  | BALT  |  | Baynesville   |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 8700 LOCH BEND      |  |   |  |           |  |
| 14. FATHER'S NAME   |  | 15. MOTHER'S MAIDEN NAME  |  |   |  |   |  |                     |  |   |  |           |  |
| HARRY   |  | NICHOLAS  |  | HARRI   |  | Zupolis   |  |                     |  |   |  |           |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)  |  | 16b. SOCIAL SECURITY NO.  |  | 17. INFORMANT   |  | ADDRESS   |  |                     |  |   |  |           |  |
| No  |  | 155 169804  |  | Christos Michaliadis  |  | 8700B Loch Bend   |  |                     |  |   |  |           |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:  |  |   |  |   |  |   |  |                     |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |  |           |  |
| IMMEDIATE CAUSE (a) CARDIAC ARREST  |  |   |  |   |  |   |  |                     |  |   |  |           |  |
| DUE TO, OR AS A CONSEQUENCE OF  |  |   |  |   |  |   |  |                     |  |   |  |           |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.  |  |   |  |   |  |   |  |                     |  |   |  |           |  |
| DUE TO, OR AS A CONSEQUENCE OF  |  |   |  |   |  |   |  |                     |  |   |  |           |  |
| (c) METASTATIC CA BREAST  |  |   |  |   |  |   |  |                     |  |   |  |           |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |   |  |   |  |   |  |                     |  |   |  |           |  |
| INTERMITTENT BOWEL OBST   |  |   |  |   |  |   |  |                     |  |   |  |           |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?      |  |                     |  |   |  |           |  |
|   |  |   |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | YES <input type="checkbox"/> NO <input type="checkbox"/>            |  |                     |  |   |  |           |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED<br>(ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |   |  |                     |  |   |  |           |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |                     |  |   |  |           |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 10/29, 19 79, to 12/5, 19 79, that (I) (we) lost saw the deceased alive on 12/5, 19 79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  | 22b. SIGNATURE<br>WTC Moore MD  |  | DEGREE<br>MD  |  | 22c. DATE SIGNED<br>12/5/79   |  |                     |  |   |  |           |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  | 22e. ADDRESS  |  |   |  |   |  |                     |  |   |  |           |  |
| MOORE   |  | U of Md Balt Md.  |  |   |  |   |  |                     |  |   |  |           |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   |  | 23b. DATE   |  | 23c. NAME OF CEMETERY OR CREMATORY  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE                          |  |                     |  |   |  |           |  |
| Burial  |  | 12/8/79   |  | Parkwood Cemetery   |  | Parkville Baltimore Md.   |  |                     |  |   |  |           |  |
| 24. FUNERAL DIRECTOR  |  | 25a. DATE REC'D. BY REGISTRAR   |  | 25b. REGISTRAR'S SIGNATURE  |  |   |  |                     |  |   |  |           |  |
| Christos Michaliadis 74011 Baltimore Rd.  |  | DEC 10 1979   |  | Christos Michaliadis  |  |   |  |                     |  |   |  |           |  |



1910

January 1st

1910

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal with the State Dept. of Health and Mental Hygiene. **IMPORTANT:** If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

7 9 3 0 4 1 0

1. FOR  
STATE  
REGISTRAR

|   |  |                         |   |   |  |   |  |   |   |  |  |   |  |
|---|--|-------------------------|---|---|--|---|--|---|---|--|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Edward K Milburn</b>   |  |                         | 2a. DATE OF DEATH<br>MONTH <b>DEC.</b> DAY <b>12</b> YEAR <b>79</b>   |   |  | 2b. HOUR<br><b>1130</b> P.M.  |  |   |   |  |  |   |  |
| 3. SEX<br><b>Male</b>   |  | 4. RACE<br><b>NEGRO</b> |   | 5. DATE OF BIRTH<br>MONTH <b>7</b> DAY <b>30</b> YEAR <b>13</b> |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>66</b> YRS.   |  | 7. IF UNDER 1 YEAR<br>MONTHS <b>0</b> DAYS <b>0</b> |   | 8. IF UNDER 24 HRS.<br>HOURS <b>0</b> MIN <b>0</b> |  |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MARYLAND</b>  |  |                         | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Balt. City</b> MD. |  |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   |  |                         | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>U. of Md. Hosp.</b> |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>LABORER</b>  |  |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>BETH. STEEL</b>       |  |  |   |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE <b>MD.</b> 13b. COUNTY <b>Balt.</b> 13c. CITY OR TOWN <b>Balt.</b> |  |                         |   |   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  |   | 13e. STREET ADDRESS<br><b>1153 N. Stricken St. 21217</b>      |  |  |   |  |
| 14. FATHER'S NAME<br>FIRST <b>ROY</b> MIDDLE <b>ROY</b> LAST <b>MILBURN</b>   |  |                         | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>CAROLINE</b> MIDDLE <b>(CARRIE)</b> LAST <b>KELLY</b>  |   |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>NO</b>  |  |   | 16b. SOCIAL SECURITY NO.<br><b>212-03-9454</b>                |  |  | 17. INFORMANT<br><b>Gerdine Milburn</b> ADDRESS<br><b>1153 N. Stricken St., Balt. Md.</b> |  |

|  |  |  |   |  |  |  |  |  |  |  |  |
|--|--|--|---|--|--|--|--|--|--|--|--|
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)<br>PART 1. DEATH WAS CAUSED BY:<br><b>4275</b> IMMEDIATE CAUSE (a) <b>Cardiac arrest</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>4275</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(c) <b>4275</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><b>Adenocarcinoma of lung.</b> |  |  |   |  |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>24 hrs.</b> |  |
| 19a. DATE OF OPERATION<br><b>12/15/79</b>  |  |  | 19b. CONDITIONS FOR WHICH OPERATION WAS PERFORMED<br><b>Adenocarcinoma of lung.</b> |  |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)<br><b>NO</b>   |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>12 15 19 79</b>               |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)              |  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>12/15</b> , 19 <b>79</b> , to <b>12/16</b> , 19 <b>79</b> , that (I) (we) last saw the deceased alive on <b>12/16</b> , 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |  |   |  |  |  |  |  |  |  |  |
| 22b. SIGNATURE<br><b>James W. Oshida</b> DEGREE <b>MD</b>  |  |  |   |  |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  |  | 22c. DATE SIGNED<br><b>12/17/79</b>  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>James W. Oshida</b>  |  |  |   |  |  | 22e. ADDRESS<br><b>U. of Md. Hospital 225 Greene St., Balt. 21201</b>  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |  |  | 23b. DATE<br><b>12/20/79</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Md. Natl Mem. Pk.</b> |  |  | 23d. LOCATION<br>CITY OR TOWN <b>Laurel</b> COUNTY <b>Balto.</b> STATE <b>MD</b> |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME <b>MARSHALL W JONES JR/4101</b> ADDRESS <b>EDMONDSON AVE</b>  |  |  |   |  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>DEC 24 1979</b>  |  |  |  |  |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| 1- FOR STATE REGISTRAR   |  | STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  | 7 9 3 0 4 1 1<br>REG. NO.   |  |
|--|--|--|--|---|--|
| 1 DECEASED NAME (TYPE OR PRINT)  |  | FIRST MIDDLE LAST<br>Clayborn Miles  |  | 2a DATE OF DEATH MONTH DAY YEAR 2b HOUR<br>12 28 79 1155 P.M.                 |  |
| 3 SEX<br>MALE  |  | 4 RACE<br>BLACK  |  | 5 DATE OF BIRTH MONTH DAY YEAR<br>1 4 1992                                    |  |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Md.  |  | 7b CITIZEN OF WHAT COUNTRY?<br>U.S.  |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br>77 YRS.                                     |  |
| 10 CITY OR TOWN OF DEATH<br>Baltimore  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>U. of Md. Hospital |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br>Balt. City MD.                         |  |
| 13a STATE<br>Md.   |  | 13b COUNTY<br>Balt.  |  | 13c CITY OR TOWN<br>Balt.   |  |
| 14 FATHER'S NAME FIRST MIDDLE LAST   |  | 15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST  |  | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Retired       |  |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>NO   |  | 16b SOCIAL SECURITY NO.<br>215-01-5981   |  | 17 INFORMANT ADDRESS<br>DEBORAH MINTER SAME                                   |  |
| 18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a)<br>5920 Sepsis + diffuse intravasc. coagulation<br>DUE TO, OR AS A CONSEQUENCE OF (b)<br>probable upper urinary tract infection, staghorn calculus<br>DUE TO, OR AS A CONSEQUENCE OF (c) |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br>Extremely poor nutrition - cachexia → probably (family will come in 12/29)  |  |  |  |   |  |
| 19a DATE OF OPERATION  |  | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>      |  |
| 21a ACCIDENT WAS UNDERLYING OR CONTRIBUTING TO CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)<br>NO   |  | 21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |
| 21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f LOCATION STREET CITY OR TOWN COUNTY STATE                                 |  |
| 22a I certify that (I) (this hospital) attended the deceased from 12/28/79 to 12/28/79, that (I) (we) lost saw the deceased alive on 12/28/79, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.                    |  |  |  |   |  |
| 22b SIGNATURE<br>J. Oshida MD  |  | DEGREE   |  | 22c DATE SIGNED<br>12/28/79   |  |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT)<br>J. Oshida MD   |  | 22e ADDRESS<br>U. of Md. Hospital  |  |   |  |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial   |  | 23b DATE<br>1/3/80   |  | 23c NAME OF CEMETERY OR CREMATORY<br>Mt. CALVARY Cem.                         |  |
| 24 FUNERAL DIRECTOR NAME<br>VERNON Bailey  |  | ADDRESS<br>1348 CALHOUN St.  |  | 25a DATE REC'D. BY REGISTRAR<br>JAN 2 1980                                    |  |
| 25b REGISTER SIGNATURE<br>R. Bailey  |  |  |  |   |  |





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| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH |  |         |   |                                 |  |  |  |                             |  | 79 30412                    |  |
|--|--|---------|---|---------------------------------|--|--|--|-----------------------------|--|-----------------------------|--|
| 1. FOR STATE REGISTRAR   |  |         | REG. NO.  |                                 |  |  |  |                             |  |                             |  |
| 1. DECEASED NAME (TYPE OR PRINT)   |  |         | FIRST MIDDLE LAST   |                                 |  | 2a. DATE OF DEATH MONTH DAY YEAR   |  |                             | 2b. HOUR   |                             |  |
| Mildred J. Milner  |  |         |   |                                 |  | 12 1 79  |  |                             | 6:55 am  |                             |  |
| 3. SEX   |  | 4. RACE |   | 5. DATE OF BIRTH MONTH DAY YEAR |  | 6. AGE (IN YEARS LAST BIRTHDAY)  |  | IF UNDER 1 YEAR MONTHS DAYS |  | IF UNDER 24 HRS. HOURS MIN. |  |
| Female   |  | White   |   | 3 31 03                         |  | 76 YRS.  |  |                             |  |                             |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  |         | 7b. CITIZEN OF WHAT COUNTRY?  |                                 |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  |                             | 9. BALTIMORE CITY OR COUNTY OF DEATH   |                             |  |
| Maryland   |  |         | U.S.A.  |                                 |  |  |  |                             | BALTIMORE CITY MD.   |                             |  |
| 10. CITY OR TOWN OF DEATH  |  |         | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)  |                                 |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |  |                             | 12b. KIND OF BUSINESS OR INDUSTRY  |                             |  |
| BALTIMORE  |  |         | ST. AGNES HOSPITAL  |                                 |  | Homemaker  |  |                             |  |                             |  |
| 13a. STATE   |  |         | 13b. COUNTY   |                                 |  | 13c. CITY OR TOWN  |  |                             | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |                             |  |
| Maryland   |  |         | Howard County   |                                 |  | Baltimore  |  |                             | 6199 Washington Blvd.  |                             |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST  |  |         | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST  |                                 |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)  |  |                             | 16b. SOCIAL SECURITY NO.   |                             |  |
| Unknown Coughlin   |  |         | Julia Unknown   |                                 |  | No   |  |                             | 213-74-7054  |                             |  |
| 17. INFORMANT ADDRESS  |  |         | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 410- Myocardial Infarction  |                                 |  | 19. DATE OF OPERATION  |  |                             | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |                             |  |
| James A. Milner, Jr. 5895 Bonnieview Lane  |  |         | DUE TO, OR AS A CONSEQUENCE OF  |                                 |  |  |  |                             | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                             |  |
|  |  |         | DUE TO, OR AS A CONSEQUENCE OF  |                                 |  |  |  |                             | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                 |                             |  |
|  |  |         | DUE TO, OR AS A CONSEQUENCE OF  |                                 |  |  |  |                             | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) |                             |  |
|  |  |         | PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Congestive heart failure  |                                 |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR   |  |                             | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |                             |  |
|  |  |         |   |                                 |  | P.M. 19  |  |                             |  |                             |  |
|  |  |         | 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |                                 |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  |                             | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |                             |  |
|  |  |         |   |                                 |  |  |  |                             |  |                             |  |
|  |  |         | 22a. I certify that (I) (this hospital) attended the deceased from 11-26-1979, to 12-1-1979, that (I) (we) lost saw the deceased alive on 12-1-1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |                                 |  | 22b. SIGNATURE G. Talhara M.D.   |  |                             | 22c. DATE SIGNED 12-1-79   |                             |  |
|  |  |         | 22d. PHYSICIAN'S NAME (TYPE OR PRINT) E. MALHOTRA M.D.  |                                 |  | 22e. ADDRESS 900 CATON AVE. BALTIMORE, MD. 21229   |  |                             |  |                             |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |  |         | 23b. DATE   |                                 |  | 23c. NAME OF CEMETERY OR CREMATORY   |  |                             | 23d. LOCATION CITY OR TOWN COUNTY STATE  |                             |  |
| Burial   |  |         | 12/4/79   |                                 |  | Stevensville Cemetery  |  |                             | Stevensville Q.A. Md.  |                             |  |
| 24. FUNERAL DIRECTOR NAME  |  |         | 24b. ADDRESS  |                                 |  | 25a. DATE REC'D. BY REGISTRAR  |  |                             | 25b. REGISTRAR'S SIGNATURE   |                             |  |
| Hubbard Funeral Home   |  |         | 4107 Wilkens Ave 21229  |                                 |  | DEC 3 1979   |  |                             | [Signature]  |                             |  |

51. 1. 2

YVES BACHELARD

1914-1962

1914-1962

1914-1962

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1914-1962

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1914-1962



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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| FOR<br>1 - STATE<br>REGISTRAR   |   | STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |   | 7 9 3 0 4 1 3<br>REG. NO.  |  |
|---|---|---|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>ANDREW L MILLER  |   |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>12 20 79                             |  | 2b. HOUR<br>2 A M  |
| 3. SEX<br>male  | 4. RACE<br>white  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>Nov. 8, 1894  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>85 YRS.   |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br>Maryland  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD.                           |  |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>ST. AGNES HOSPITAL |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Laborer |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>City Gov't.   |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>Maryland  |   |   | 13b. COUNTY<br>Howard   | 13c. CITY OR TOWN<br>Elkridge  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST  |   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST                               |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>no  |   | 16b. SOCIAL SECURITY NO.<br>212-22-9026   |   | 17. INFORMANT<br>Mrs. Doris Blakley  |  |
|   |   |   |   | ADDRESS<br>7734 Washington Blvd.   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>cardiorespiratory arrest</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <u>ARDS</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>Fat emboli 2° to Hip Fx</u> |   |   |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):<br><u>Fractured left hip -</u>   |   |   |   |  |  |
| 19a. DATE OF OPERATION  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)       |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>12-20-79</u> 19 <u>79</u> to <u>12-20-79</u> 19 <u>79</u> , that (I) (we) last saw the deceased alive on <u>12-20-79</u> 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                          |   |   |   |  |  |
| 22b. SIGNATURE<br><u>[Signature]</u>  |   | DEGREE  |   | 22c. DATE SIGNED<br>12/30/79   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Mario PLAZA PONTE  |   | 22e. ADDRESS<br>900 CATON AVE. BALTIMORE, MD. 21229   |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>burial  |   | 23b. DATE<br>12/22/79   | 23c. NAME OF CEMETERY OR CREMATORY<br>Meadowridge Cemetery                  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Dorsey Howard Maryland   |
| 24. FUNERAL DIRECTOR<br>NAME<br>Ambrose Funeral Home  |   |   | 25a. DATE REC'D. BY REGISTRAR<br>DEC 21 1979                                |  | 25b. REGISTRAR'S SIGNATURE<br><u>[Signature]</u>   |
|   |   |   | ADDRESS<br>1328 Sulphur Spring Rd.  |  |  |

100-30413

U.S. DEPARTMENT OF JUSTICE  
FEDERAL BUREAU OF INVESTIGATION

BALTIMORE CITY

ST. ANNES HOSPITAL

BALTIMORE

U.S. DEPARTMENT OF JUSTICE  
FEDERAL BUREAU OF INVESTIGATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH7930414  
REG. NO.

|   |  |  |   |   |  |  |   |
|---|--|--|---|---|--|--|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>Sadie E. Miller   |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>12 23 79 |   |  | 2b. HOUR<br>9-15 P M   |   |
| 3. SEX<br>Female  |  | 4. RACE<br>Black   |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>9 25 96   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>83 YRS.   |   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.   |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.   |   |
| 10. CITY OR TOWN OF DEATH<br>Baltimore  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Lafayette Square Nhrs. Center |   |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)   |   |
| 13a. STATE<br>Maryland  |  | 13b. COUNTY  |   | 13c. CITY OR TOWN<br>Baltimore  |  | 13d. STREET ADDRESS<br>1701 Utaw Place   |   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST  |  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST   |  |  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)  |  | 16b. SOCIAL SECURITY NO<br>(IF YES, GIVE WAR OR DATES)   |   | 17. INFORMANT ADDRESS   |  |  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Cardiac arrest<br>4029<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) Hypertensive Heart disease<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) Cerebrovascular accidents                    |  |  |   |   |  |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br>Virecent<br>several yrs<br>2 yrs |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |  |   |   |  |  |   |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |   | 21c. HOW INJURY OCCURRED<br>(ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |  |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |   |
| 22a. I certify that (I) (this hospital) attended the deceased from 10/22 1979 to 12/24 1979, that (I) (we) last saw the deceased alive on 12/18/79 1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |   |   |  |  |   |
| 22b. SIGNATURE<br>Amstun N. Naeem MD  |  |  |   | DEGREE<br>MD ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                |  | 22c. DATE SIGNED<br>12/25/79   |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>AMATUN, N. NAEEM   |  |  |   | 22e. ADDRESS<br>501 Dolphin Street Baltimore MD 21217   |  |  |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial  |  | 23b. DATE<br>12-28-79  |   | 23c. NAME OF CEMETERY OR CREMATORY<br>Arbutus MEM.  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>BALTO. Md.   |   |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br>VERNON BAILEY 1348 CALHOUN ST.  |  |  |   | 25a. DATE REC'D. BY REGISTRAR<br>DEC 26 1979  |  |  |   |
|   |  |  |   | 25b. REGISTRAR'S SIGNATURE<br>L. J. McCreedy  |  |  |   |



DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

7 9 3 0 4 1 5

REG. NO.

1 - FOR  
STATE  
REGISTRAR

|  |  |   |   |   |   |  |   |  |  |
|--|--|---|---|---|---|--|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><i>VIRGINIA C. MILLER</i>  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><i>12-19-1979</i>                          |   |   | 2b. HOUR<br><i>1 P. M.</i>   |   |  |  |
| 3. SEX<br><i>F</i>   |  | 4. RACE<br><i>WHITE</i>   |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><i>4-21-1911</i>  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><i>68</i>   |   | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><i>WISCONSIN</i>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><i>U.S.A.</i>   |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><i>BALTIMORE CITY</i> MD.  |   |  |  |
| 10. CITY OR TOWN OF DEATH<br><i>BALTO.</i>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><i>2806 CLEARVIEW AVE.</i> |   |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><i>SALES LADY</i>  |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><i>DEPT. STORE</i>  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  |   |   |   |   |  |   |  |  |
| 13a. STATE<br><i>MD.</i>   |  | 13b. COUNTY<br><i>BALTO.</i>  |   | 13c. CITY OR TOWN<br><i>BALTO.</i>  |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |   | 13e. STREET ADDRESS<br><i>2806 CLEARVIEW AVE.</i>  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><i>STANLEY KINN</i>  |  |   |   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><i>MARIA KWIATKOWSKI</i> |  |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><i>NO</i>  |  |   |   |   | 16b. SOCIAL SECURITY NO.<br><i>081-07-1434</i>                            |  |   |  |  |
| 17. INFORMANT<br><i>Mr. Wm. Miller 222 Foxmuth Rd. Richmond, Va.</i>   |  |   |   |   | ADDRESS   |  |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Metastatic Adenocarcinoma of The Colon</i><br>DUE TO, OR AS A CONSEQUENCE OF (b) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) _____<br>DUE TO, OR AS A CONSEQUENCE OF (c) _____<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): |  |   |   |   |   |  |   |  |  |
| MEDICAL CERTIFICATION  |  |   |   |   |   |  |   |  |  |
| 19a. DATE OF OPERATION<br><i>9/79</i>  |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><i>Intestinal obstruction</i> |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><i>P.M. 19</i>                 |   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |   |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)            |   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>7/20/79</i> to <i>12/19/79</i> , that (I) (we) last saw the deceased alive on <i>12/12/79</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.   |  |   |   |   |   |  |   |  |  |
| 22b. SIGNATURE<br><i>John W. Bowie MD</i>  |  |   |   |   |   | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |   | 22c. DATE SIGNED<br><i>12/20/79</i>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  |   |   |   |   | 22e. ADDRESS   |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><i>BURIAL</i>  |  |   | 23b. DATE<br><i>12-21-1979</i>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><i>PARKWOOD CEMETERY</i>            |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><i>BALTO. Md.</i> |  |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><i>Harvey Miller 7527 Hayford Rd.</i>  |  |   |   |   |   | 25a. DATE REC'D. BY REGISTRAR<br><i>DEC 20 1979</i>  |   | 25b. REGISTRAR'S SIGNATURE<br><i>Robert M. Brady</i>   |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Intestusurda lanitotui

PR/P



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |   |   |  | 7 9 3 0 4 1 6   |  |  |  |
|---|---|---|--|---|--|--|--|
| 1. FOR STATE REGISTRAR  |   |   |  | REG. NO.  |  |  |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br><b>WILLIAM E. MILLER, Sr.</b>   |   |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>12 14 79</b>                           |   | 2b. HOUR<br><b>1:05A</b>   |  |  |
| 3. SEX<br><b>Male</b>   | 4. RACE<br><b>White</b>   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>May 6, 1899</b>  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>80</b>                                     |   | 7. IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN. |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.                |   |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Union Memorial Hospital</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Clerk</b> |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Sales</b>                  |  |  |
| 13a. STATE<br><b>Maryland</b>   |   | 13b. COUNTY<br><b>-</b>   | 13c. CITY OR TOWN<br><b>Baltimore</b>  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>William Miller</b>   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Elizabeth Yeager</b>  |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>   |   | 16b. SOCIAL SECURITY NO.<br><b>-</b>  |  | 17. INFORMANT ADDRESS<br><b>Edith M. Miller, same address</b>                                   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>GRAM NEGATIVE SEPSIS</b><br><b>0384</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |   |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><b>ACUTE RENAL FAILURE</b>   |   |   |  |   |  |  |  |
| 19a. DATE OF OPERATION<br><b>10/25/79</b>   |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>GANGRENE OF LEFT LEG</b>   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>10/25</b> , 19 <b>79</b> , to <b>12/14</b> , 19 <b>79</b> , that (I) (we) last saw the deceased alive on <b>12/14</b> , 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.       |   |   |  |   |  |  |  |
| 22b. SIGNATURE<br><b>James D. Gallant MD</b>  |   | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>        |  |   |  | 22c. DATE SIGNED<br><b>12/14/79</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>JAMES D. GALLANT, M.D.</b>  |   | 22e. ADDRESS<br><b>UNION MEMORIAL HOSPITAL</b>  |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>  |   | 23b. DATE<br><b>12/17/79</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Gardens of Faith</b>                                   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore, Maryland</b>   |  |
| 24. FUNERAL DIRECTOR<br><b>Scrimunek Funeral Home, Inc.</b>   |   | ADDRESS<br><b>3331 Brehms Lane Balto., Md. 21213</b>  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>DEC 18 1979</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>R. J. McCreedy</b>  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  |   |  |  |  |  |   |  |
|--|--|--|--|---|--|--|--|--|---|--|
| FOR<br>1- STATE REGISTRAR  |  |  |  |   | REG. NO. 7 9 3 0 4 1 7   |  |  |  |   |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>JOHN MILLINGTON</b>   |  |  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>12 - 27 - 79</b>   |  |  | 2b. HOUR<br><b>3:50 PM</b>   |   |  |
| 3. SEX<br><b>M</b>   |  | 4. RACE<br><b>B</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>3 1 1904</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>75</b> YRS                               |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN   |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.              |  |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>SINAI HOSPITAL</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)               |  | 12b. KIND OF BUSINESS OR INDUSTRY  |   |  |
| 13a. STATE<br><b>Maryland</b>  |  |  |  |   | 13b. COUNTY  |  | 13c. CITY OR TOWN<br><b>Baltimore</b>                            |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>ERNEST MILLINGTON</b>   |  |  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>UNKN.</b>  |  |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>  |  |  |  |   | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>216-01-7158</b>  |  | 17. INFORMANT<br>ADDRESS<br><b>ANNA B. CORBETT Same As Above</b> |  |   |  |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br><b>1490</b><br>IMMEDIATE CAUSE (a) <b>metastatic Carcinoma of pharynx</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |  |  |   |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)  |  |  |  |   |  |  |  |  |   |  |
| 19a. DATE OF OPERATION   |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>      |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>12/14</b> , 19 <b>79</b> , to <b>12/27</b> , 19 <b>79</b> , that (I) (we) lost saw the deceased alive on <b>12/27</b> , 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.                |  |  |  |   |  |  |  |  |   |  |
| 22b. SIGNATURE<br><b>Robert A. Wacks</b> M.D.  |  |  |  |   | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  |  | 22c. DATE SIGNED<br><b>12/27/79</b>  |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Robert A. Wacks</b>  |  |  |  |   | 22e. ADDRESS<br><b>Sinai Hosp. of Balt.</b>  |  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |  |  | 23b. DATE<br><b>12-31-79</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>MD. NAT. MEM. PK.</b>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>LAUREL MD.</b>  |  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Wm. C. March F/H 1101 E. North Ave.</b>   |  |  |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>DEC 31 1979</b>                            |  | 25b. REGISTRAR'S SIGNATURE<br><b>Henry McCreedy</b>  |   |  |

VI 100

1-11

Handwritten notes on lined paper, including a circled "100" and various illegible scribbles.

STATE OF MARYLAND  
DEPT. OF HEALTH AND MENTAL HYGIENE

Date.....1/10/80.....

To .....Kathy.....

From .....Dee.....

- |  |   |
|--|---|
| <input type="checkbox"/> Please Note & File                            | <input type="checkbox"/> To be Signed   |
| <input type="checkbox"/> For Your Information                          | <input type="checkbox"/> Please Comment |
| <input type="checkbox"/> Please Note & Return                          | <input type="checkbox"/> Please See Me  |
| <input type="checkbox"/> Please Handle                                 |   |
| <input type="checkbox"/> Please answer, Sending me Copy of your letter |   |
| <input type="checkbox"/> Please Prepare reply for my Signature         |   |

Remarks:

Please query item 7a

Thanks



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |   |  |  |  |   |  |   |  |
|--|--|---|--|--|--|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>James A. Milton   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>12 9 79 |  |  | 2b. HOUR<br>M   |  |   |  |
| 3 SEX<br>M   |  | 4 RACE<br>B   |  | 5 DATE OF BIRTH<br>MONTH DAY YEAR<br>2 24 21   |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br>58                                      |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>N.C.  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |  | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.                 |  |   |  |
| 10. CITY OR TOWN OF DEATH<br>Balto.  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>506 N. Carrollton Avenue |  |  |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)          |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a STATE<br>Md.   |  | 13b. COUNTY<br>Balto.   |  | 13c. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 13d. STREET ADDRESS<br>506 N. Carrollton Ave.                             |  |   |  |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST  |  |   |  | 15 MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Annie Taylor   |  |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>Yes  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>WWII   |  | 17 INFORMANT<br>Thelma C. Milton   |  | ADDRESS<br>506 Carrollton Ave.  |  |   |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>CONGESTIVE HEART FAILURE</u><br><u>4292</u><br>DUE TO, OR AS A CONSEQUENCE OF <u>AND ATRHYTHMIA</u><br>(b) <u>ATHEROSCLEROTIC CARDIOVASCULAR DISEASE</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)      |  |   |  |  |  |   |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br>10 yrs   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):<br><u>CHRONIC RENAL FAILURE</u>   |  |   |  |  |  |   |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |   |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |   |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19 <u>77</u> , to _____, 19 <u>79</u> , that (I) (we) last saw the deceased alive on <u>12/5/79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |   |  |  |  |   |  |   |  |
| 22b. SIGNATURE<br>Mohamed S Al-Ibrahim   |  |   |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>       |  |   |  | 22c. DATE SIGNED<br>12/12/79  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>MOHAMED S AL-IBRAHIM  |  |   |  | 22e. ADDRESS<br>VA MEDICAL CENTER<br>3900 Loch Raven Blvd 21218  |  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial   |  | 23b. DATE<br>12/12/79   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>King Memorial Pk.  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore Co., Md.          |  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Wm C March F/H   |  |   |  | ADDRESS<br>1101 E. North Ave.  |  | 25a. DATE REC'D. BY REGISTRAR<br>DEC 12 1979                              |  | 25b. REGISTRAR'S SIGNATURE<br>R. H. H. H.   |  |





TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR THE FUNERAL DIRECTOR. PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| FOR<br>1- STATE REGISTRAR  |  |                  |  |   |   |  |  |   |  | STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH   |  |  |  |                       |   |  |  |  |  | REG. NO. 30419   |  |  |  |  |
|--|--|------------------|--|---|---|--|--|---|--|---|--|--|--|-----------------------|---|--|--|--|--|--|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Evqlyn L. Minnich   |  |                  |  |   | 2a. DATE KNOWN OF DEATH<br>ESTIMATED <input checked="" type="checkbox"/> 12 4 19 79   |  |  |   |  | 2b. HOUR<br>M   |  |  |  |                       |   |  |  |  |  |  |  |  |  |  |
| 3. SEX<br>female   |  | 4. RACE<br>white |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>6 23 15 |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>61 YRS. |  | IF UNDER 1 YR.<br>MONTHS DAYS HOURS MIN |  | IF UNDER 24 HRS.  |  | 2c. DATE PRONOUNCED DEAD<br>12 5 19 79 |  | 2d. HOUR<br>1:51 P.M. |   |  |  |  |  |  |  |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Pennsylvania  |  |                  |  |   | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |  |  |   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  |  |                       | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.                                      |  |  |  |  |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore   |  |                  |  |   | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>3445 Hickory Avenue |  |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Retired  |  |  |  |                       | 12b. KIND OF BUSINESS OR INDUSTRY   |  |  |  |  |  |  |  |  |  |
| 13a. STATE<br>Maryland   |  |                  |  |   | 13b. COUNTY   |  |  |   |  | 13c. CITY OR TOWN<br>Baltimore  |  |  |  |                       | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  |  |  | 13e. STREET ADDRESS<br>3445 Hickory Ave.   |  |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Claude A. Axer   |  |                  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Ethel R. Sliger  |  |  |   |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br>no   |  |  |  |                       | 16b. SOCIAL SECURITY NO.<br>167-14-7452   |  |  |  |  | 17. INFORMANT ADDRESS<br>Mechanicsburg, Penna<br>W. Kenneth Hull 135 W. Main St. |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>4292 IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b) DUE TO, OR AS A CONSEQUENCE OF<br>(c) DUE TO, OR AS A CONSEQUENCE OF  |  |                  |  |   |   |  |  |   |  |   |  |  |  |                       | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |  |  |  |  |  |  |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).  |  |                  |  |   |   |  |  |   |  |   |  |  |  |                       |   |  |  |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  |                  |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |  |  |   |  |   |  |  |  |                       | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>             |  |  |  |  |  |  |  |  |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |  |                  |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  |  |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)   |  |  |  |                       |   |  |  |  |  |  |  |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK  |  |                  |  |   | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)   |  |  |   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |                       |   |  |  |  |  |  |  |  |  |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |  |                  |  |   |   |  |  |   |  |   |  |  |  |                       |   |  |  |  |  |  |  |  |  |  |
| ACTUAL SIGNATURE<br>Margaret DeKrell   |  |                  |  |   | TITLE (SPECIFY)<br>Assistant MEDICAL EXAMINER   |  |  |   |  | DATE SIGNED<br>12/6/79  |  |  |  |                       |   |  |  |  |  |  |  |  |  |  |
| EXAMINER'S NAME (TYPE OR PRINT)<br>Margarita A. Korell, M.D.   |  |                  |  |   | ADDRESS<br>111 Penn Street, Balto MD 21201  |  |  |   |  |   |  |  |  |                       |   |  |  |  |  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial  |  |                  |  |   | 23b. DATE<br>12/8/79  |  |  |   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Woodlawn Cemetery   |  |  |  |                       | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore, Md.                                    |  |  |  |  |  |  |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>A. Alan Seitz, Jr.   |  |                  |  |   | ADDRESS<br>Funeral Home 3818 Roland Ave.  |  |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br>DEC 7 1979   |  |  |  |                       | 25b. REGISTRAR'S SIGNATURE<br>Anthony McBrady   |  |  |  |  |  |  |  |  |  |

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CHARTER OF THE

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |  |  |  |  |  |  |  |  |  | REG. NO. 30420   |  |
|--|--|--|--|--|--|--|--|--|--|--|--|
| 1. FOR STATE REGISTRAR   |  |  |  |  |  |  |  |  |  |  |  |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br><b>John T. Misiora</b>   |  |  |  |  |  |  |  |  |  | 2a. DATE KNOWN OF DEATH ESTI- MATED <input checked="" type="checkbox"/> MONTH DAY YEAR<br><b>12 24 19 79</b>                             |  |
| 3. SEX Male 4. RACE White 5. DATE OF BIRTH MONTH DAY YEAR <b>1-28-1892</b> 6. AGE (IN YEARS LAST BIRTHDAY) <b>87</b> YRS. 7. IF UNDER 1 YR. MONTHS DAYS 7. IF UNDER 24 HRS. HOURS MIN.   |  |  |  |  |  |  |  |  |  | 2b. HOUR <b>10:42</b> AM   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>POLAND</b> 7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b> 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>  |  |  |  |  |  |  |  |  |  | 2c. DATE PRONOUNCED DEAD <b>12 24 19 79</b> 2d. HOUR <b>10:42</b> AM   |  |
| 9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City, MD.</b>  |  |  |  |  |  |  |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH <b>Baltimore</b> 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>6201 Carter Avenue</b>   |  |  |  |  |  |  |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>CUSTOM TAILOR</b>   |  |
| 12b. KIND OF BUSINESS OR INDUSTRY <b>TAILORING</b>   |  |  |  |  |  |  |  |  |  |  |  |
| 13a. STATE <b>MD.</b> 13b. COUNTY <b>—</b> 13c. CITY OR TOWN <b>BAKTO.</b>   |  |  |  |  |  |  |  |  |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> 13e. STREET ADDRESS <b>6201 CARTER AVE.</b> |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST <b>MATTHEW MISIORA</b>   |  |  |  |  |  |  |  |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>AGATHA SEGDA</b>   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>No</b> (IF YES, GIVE WAR OR DATES) <b>—</b> 16b. SOCIAL SECURITY NO. <b>—</b>  |  |  |  |  |  |  |  |  |  | 17. INFORMANT ADDRESS <b>Mrs. Salhan Misiora - 6201 Carter Ave.</b>  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic Cardiovascular Disease</b><br><b>4292</b> DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b) <b>—</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>—</b>   |  |  |  |  |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).  |  |  |  |  |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |  |  |  |  |  |  |  |  |  | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |  |  |  |  |  |  |  |  |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |  |  |  |  |  |  |  |  |  |  |
| 22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion |  |  |  |  |  |  |  |  |  |  |  |
| ACTUAL SIGNATURE <b>Virginia L. Dolan</b> TITLE (SPECIFY) <b>Assistant</b> MEDICAL EXAMINER DATE SIGNED <b>12/25/79</b>  |  |  |  |  |  |  |  |  |  |  |  |
| EXAMINER'S NAME (TYPE OR PRINT) <b>Virginia L. Dolan, M.D.</b> ADDRESS <b>111 Penn Street</b>  |  |  |  |  |  |  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b> 23b. DATE <b>12-29-79</b> 23c. NAME OF CEMETERY OR CREMATORY <b>MORELAND MEMORIAL</b> 23d. LOCATION CITY OR TOWN COUNTY STATE <b>BAKTO., MD.</b>   |  |  |  |  |  |  |  |  |  |  |  |
| 24. FUNERAL DIRECTOR NAME <b>Harold R. Dolan</b> ADDRESS <b>7527 Harford Rd.</b> 25a. DATE REC'D. BY REGISTRAR <b>DEC 26 1979</b> 25b. REGISTRAR'S SIGNATURE <b>L. J. H. H. H.</b>   |  |  |  |  |  |  |  |  |  |  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |   |  |  |   |  |  |   | 7 9 3 0 4 2 1  |  |
|--|--|---|---|--|--|---|--|--|---|--|--|
| FOR<br>1 - STATE<br>REGISTRAR  |  |   | REG. NO.  |  |  |   |  |  |   |  |  |
| 1 DECEASED NAME<br>(TYPE OR PRINT) <b>MACK</b>   |  |   |   |  | 2a DATE OF DEATH<br>MONTH <b>12</b> DAY <b>27</b> YEAR <b>79</b>                               |   |  |  |   | 2b HOUR<br><b>530P</b> M   |  |
| 3 SEX<br><b>Male</b>   |  | 4 RACE<br><b>Black</b>  |   | 5 DATE OF BIRTH<br>MONTH <b>5</b> DAY <b>19</b> YEAR <b>01</b>   |  |   | 6 AGE (IN YEARS LAST BIRTHDAY)<br><b>78</b> YRS  |  | IF UNDER 1 YEAR<br>MONTHS <b>0</b> DAYS <b>0</b>      |  | IF UNDER 24 HRS<br>HOURS <b>0</b> MIN <b>0</b> |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>N.C.</b>  |  | 7b CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |   | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |   | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD                                |  |   |  |  |
| 10 CITY OR TOWN OF DEATH<br><b>Baltimore</b>   |  | 11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>JOHNS HOPKINS HOSPITAL</b> |   |  |  |   | 12a USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)                                |  | 12b KIND OF BUSINESS OR INDUSTRY                      |  |  |
| 13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a STATE<br><b>Maryland</b>  |  |   | 13b COUNTY<br><b>Baltimore</b>  |  | 13c CITY OR TOWN<br><b>Baltimore</b>   |   | 13d INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e STREET ADDRESS<br><b>1313 Patterson Park Ave.</b> |  |  |
| 14 FATHER'S NAME<br>FIRST <b>FLEM</b> MIDDLE <b>MITCHELL</b> LAST <b>MITCHELL</b>  |  |   |   |  | 15 MOTHER'S MAIDEN NAME<br>FIRST <b>BERTHA</b> MIDDLE <b>WITCHFIELD</b> LAST <b>WITCHFIELD</b> |   |  |  |   |  |  |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>   |  |   | 16b SOCIAL SECURITY NO.<br><b>217-07-1255</b>                                       |  | 17 INFORMANT<br>ADDRESS<br><b>MODAE R. MITCHELL 1737 E. Lafayette</b>                          |   |  |  |   |  |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <b>Cardiac arrest</b>  |  |   |   |  |  |   |  |  |   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br><b>30 seconds</b> |  |
| 1991<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Severe acidosis</b>  |  |   |   |  |  |   |  |  |   | <b>24 hours</b>  |  |
| DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Respiratory failure</b>   |  |   |   |  |  |   |  |  |   | <b>4 days</b>  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)<br><b>Right Lung Pneumonia secondary to obstruction by Cancer MASS</b>  |  |   |   |  |  |   |  |  |   |  |  |
| 19a DATE OF OPERATION<br><b>NONE</b>   |  |   | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>NONE</b>                      |  |  | 20a AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>       |   |  |  |
| 21a ACCIDENT WAS UNDERLYING OR CONTRIBUTING TO CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)<br><b>N/A</b>   |  |   | 21b TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. <b>N/A</b> <b>19</b>         |  | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)<br><b>N/A</b>    |   |  |  |   |  |  |
| 21d INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> WHILE AT HOME <input checked="" type="checkbox"/> WHILE ON TRAVEL <input type="checkbox"/><br><b>N/A</b>   |  |   | 21e PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)<br><b>N/A</b> |  | 21f LOCATION<br>STREET <b>N/A</b>  |   | CITY OR TOWN   |  | COUNTY  | STATE  |  |
| 22a I certify that (I) (this hospital) attended the deceased from <b>Dec. 23rd</b> , 19 <b>79</b> , to <b>Dec. 27</b> , 19 <b>79</b> , that (I) (we) last saw the deceased alive on <b>12-27</b> , 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |   |   |  |  |   |  |  |   |  |  |
| 22b SIGNATURE<br><b>Roderick D. Woods, M.D.</b>  |  |   |   |  | DEGREE<br><b>M.D.</b>  |   |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |   | 22c DATE SIGNED<br><b>12-27-79</b>                                   |  |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Roderick D. Woods, M.D.</b>   |  |   |   |  | 22e ADDRESS<br><b>Johns Hopkins Hospital</b>   |   |  |  |   |  |  |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>  |  |   | 23b DATE<br><b>12-21-79</b>   |  | 23c NAME OF CEMETERY OR CREMATORY<br><b>Baltimore Cem.</b>                                     |   |  | 23d LOCATION<br>CITY OR TOWN <b>Baltimore</b> COUNTY <b>Baltimore</b> STATE <b>MD.</b>   |   |  |  |
| 24 FUNERAL DIRECTOR<br>NAME <b>Wm. C. March F/H</b> ADDRESS <b>1101 E. North Ave.</b>  |  |   |   |  | 25a DATE REC'D. BY REGISTRAR<br><b>DEC 31 1979</b>   |   | 25b REGISTRAR'S SIGNATURE<br><b>Rodney McCreedy</b>  |  |   |  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

7 9 3 0 4 2 2  
REG. NO.

|   |   |   |   |  |  |
|---|---|---|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>NATALIE XXXXX Jean Moats</b>  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>12-08-79</b>  |   | 2b. HOUR<br><b>6:04 A.M.</b>   |  |
| 3. SEX<br><b>Female</b>   | 4. RACE<br><b>White</b>   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>July 14, 1960</b>  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>19</b> YRS.                                    |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Md.</b>   | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.                    |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>UNION MEMORIAL HOSPITAL</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Telephone Operator</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY            |
| 13a. STATE<br><b>Md.</b>  |   | 13b. COUNTY<br><b>Baltimore</b>   | 13c. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13d. STREET ADDRESS<br><b>2703 N. Howard Street</b>                                  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Richard Charles Hall</b>   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Loretta Mae Hiser</b>   |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>no</b>   |   | 16b. SOCIAL SECURITY NO.<br><b>214-76-8366</b>  |   | 17. INFORMANT ADDRESS<br><b>Mrs. Loretta Mae Hiser same</b>                          |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Khalidomyosarcoma</b><br><b>1719</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |   |   |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |   |   |   |  |  |
| 19a. DATE OF OPERATION  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)       |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>11/28</b> 19 <b>79</b> to <b>12/8</b> 19 <b>79</b> , that (I) (we) last saw the deceased alive on <b>12/7</b> 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.             |   |   |   |  |  |
| 22b. SIGNATURE<br><b>D. Berliner</b>  |   | DEGREE<br><b>MD</b>   |   | 22c. DATE SIGNED   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>D. Berliner MD</b>  |   | 22e. ADDRESS<br><b>Union Memorial Hospital</b>  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>  |   | 23b. DATE<br><b>Dec. 12, 1979</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Lakeview Memorial</b>                       |  |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Eldersburg Carroll Md.</b>   |   | 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Leonard J. Ruck Inc. Baltimore, Maryland</b>   |   |  |  |
| 25a. DATE REC'D BY REGISTRAR  |   | 25b. REGISTRAR'S SIGNATURE<br><b>Robert M. Hardy</b>  |   |  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  | REG. NO. 79 30423  |  |  |  |
|---|--|---|--|--|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>MANNIE MOBLEY</b>   |  |   |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>DECEMBER 25, 1979</b>   |  |  |  |
| 3 SEX<br><b>Female</b> Male   |  |   |  | 2b. HOUR<br><b>01:30 PM</b>  |  |  |  |
| 4 RACE<br><b>Black</b>  |  | 5 DATE OF BIRTH MONTH DAY YEAR<br><b>1 1 21</b>   |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br><b>58</b> YRS.   |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>S.C.</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>THE JOHNS HOPKINS HOSPITAL</b> |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>Maryland</b>  |  |   |  | 13b. COUNTY<br><b>Baltimore</b>  |  | 13c. STREET ADDRESS<br><b>835 E. Chase St.</b>   |  |
| 14 FATHER'S NAME FIRST MIDDLE LAST<br><b>MANIE MOBLEY</b>   |  |   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>UNKN.</b>   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br><b>NO</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>248-34-2717</b>  |  | 17. INFORMANT ADDRESS<br><b>JOHN MOBLEY 2327 N. Calvert St.</b>  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a).<br><b>431- BRAIN STEM INFARCTION</b><br>DUE TO, OR AS A CONSEQUENCE OF (b).<br><b>CEREBELLAR HEMATOMA</b><br>DUE TO, OR AS A CONSEQUENCE OF (c).<br><b>High Blood Pressure</b><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>14 hours</b><br><b>20 days</b> |  |   |  |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).<br><b>Pneumonia, Azotemia, Urinary Tract Infection</b>   |  |   |  |  |  |  |  |
| 19a. DATE OF OPERATION<br><b>12/8/79, 12/18/79</b>  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>Cerebellar Hematoma + Infection</b>  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><b>19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>12/25, 1979</b> to <b>12/25, 1979</b> , that (I) (we) most saw the deceased alive on <b>12/25, 1979</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |   |  |  |  |  |  |
| 22b. SIGNATURE<br><b>Barry MacGraw</b> MD   |  |   |  | DEGREE<br><b>MD</b>  |  | 22c. DATE SIGNED<br><b>12/25/79</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>ARRY MACGRAN MD</b>   |  |   |  | 22e. ADDRESS<br><b>Johns Hopkins Hospital, Balt. Md. 21205</b>   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>12-29-79</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>MT. CALVARY CEM.</b>  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><b>ANNE ARUNDEL CO., MD.</b>  |  |
| 24. FUNERAL DIRECTOR NAME<br><b>Wm. C. March F/H, 1101 E. North Ave.</b>  |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>DEC 31 1979</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>Anthony A. Brady</b>  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

7 9 3 0 4 2 4  
REG. NO.

|   |  |  |   |   |  |  |  |  |  |
|---|--|--|---|---|--|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>CARL L. MOLLOCK</b>   |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>DECEMBER 24, 1979</b> |   |  | 2b. HOUR<br><b>12:28</b>   |  |  |  |
| 3. SEX<br><b>M</b>  |  | 4. RACE<br><b>B</b>  |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>7 27 10</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>69</b> YRS                                     |  | # UNDER 1 YEAR<br>MONTHS DAYS<br><b>0 0</b>  |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br><b>Md.</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD                     |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Balto.</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>THE JOHNS HOPKINS HOSPITAL</b> |   |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)                     |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br><b>Md.</b>  |  | 13b. COUNTY<br><b>Balto.</b>   |   | 13c. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 13d. STREET ADDRESS<br><b>1516 Holbrook Street</b>                                   |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>John Mollock</b>   |  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Amy</b>   |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>216-01-0215</b>  |   | 17. INFORMANT<br><b>Queenie Mollock</b>   |  | ADDRESS<br><b>1516 Holbrook Ave.</b>   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>PROBABLE CARDIO RESPIRATORY ARREST</b><br><b>1629</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(b) <b>METASTATIC LUNG CANCER</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) |  |  |   |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).<br><b>0</b>  |  |  |   |   |  |  |  |  |  |
| 19a. DATE OF OPERATION<br><b>0</b>  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>0</b>   |   |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)<br><b>NOT APPLICABLE</b>   |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)<br><b>NA</b>  |   | 21f. LOCATION<br>STREET<br><b>NA</b>  |  | CITY OR TOWN<br><b>NA</b>  |  | COUNTY<br><b>NA</b>  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>12/24</b> 19 <b>79</b> , to <b>12/24/79</b> 19 <b>79</b> , that (I) (we) last saw the deceased alive on <b>12/24</b> 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |  |   |   |  |  |  |  |  |
| 22b. SIGNATURE<br><b>V. Collins</b>   |  |  |   | DEGREE<br><b>MD</b>   |  |  |  | 22c. DATE SIGNED<br><b>12/24/79</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>V. corner</b>   |  |  |   | 22e. ADDRESS<br><b>JOHNS HOPKINS HOSPITAL<br/>601 NORTH BROADWAY</b>  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>12/28/79</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Liners R. Comm Cem.</b>  |  | 23d. LOCATION<br>CITY OR TOWN<br><b>Cambridge Md</b>                                 |  | COUNTY<br><b>Md</b>  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Wm C March F/H</b>   |  |  |   | ADDRESS<br><b>1101 E. North Ave.</b>  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>DEC 28 1979</b>                                  |  | 25b. REGISTRAR'S SIGNATURE<br><b>Robert Kelly</b>  |  |

BP

DHMH-16 25M  
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THE JAMES H. HARRIS HOSPITAL

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  | 779 30425<br>REG. NO  |  |   |  |  |  |  |  |
|---|--|---|--|---|--|---|--|--|--|--|--|
| 1. FOR STATE REGISTRAR  |  |   |  | 2a. DATE OF DEATH MONTH DAY YEAR  |  |   |  | 2b. HOUR   |  |  |  |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br>JOHN J. MONAGHAN  |  |   |  | DECEMBER 26, 1979   |  |   |  | 6:00 P M   |  |  |  |
| 3. SEX<br>Male  |  | 4. RACE<br>White  |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>Nov. 8, 1899   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>80 YRS.  |  | 7. IF UNDER 1 YEAR MONTHS DAYS   |  | 8. IF UNDER 24 HRS. HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Ireland  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD.                                      |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>UNION MEMORIAL HOSPITAL |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Metal Mechanic                 |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Aircraft  |  |  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>Maryland   |  |   |  | 13b. COUNTY<br>Baltimore  |  | 13c. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13d. STREET ADDRESS<br>713 E. 41st Street  |  |  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>John Monaghan  |  |   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Rose Black  |  |   |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>Yes  |  |   |  | 16b. SOCIAL SECURITY NO.<br>217 07 6313   |  | 17. INFORMANT ADDRESS<br>Mrs. Margaret Monaghan Same  |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) CVA (cerebro vascular accident)<br>436-<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b)<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)   |  |   |  |   |  |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)   |  |   |  |   |  |   |  |  |  |  |  |
| 19a. DATE OF OPERATION  |  |   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)                  |  |  |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  |   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |  |  |  |  |
| 22. I certify that (I) (this hospital) attended the deceased from 12/01, 1977, to 12/26, 1977, that (I) (we) last saw the deceased alive on 12/26, 1977, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) (did) (did not) view the body after death. |  |   |  |   |  |   |  |  |  |  |  |
| 22b. SIGNATURE<br>F. THOMAS M.D.  |  |   |  | DEGREE M.D. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>      |  |   |  | 22c. DATE SIGNED<br>12/26/79   |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>F. THOMAS M.D.   |  |   |  | 22e. ADDRESS<br>UNION MEMORIAL HOSPITAL   |  |   |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial   |  |   |  | 23b. DATE<br>12/29/79   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>New Cathedral   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br>Baltimore, Md.                            |  |  |  |
| 24. FUNERAL DIRECTOR NAME<br>Henry W. Jenkins & Sons Co.<br>4905 York Road Balto., Md. 21212  |  |   |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br>DEC 27 1978  |  | 25b. REGISTRAR'S SIGNATURE<br>[Signature]  |  |  |  |

25.06.71

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17  
(VA 15 ME (5))  
30M 7/73

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 7 9 3 0 4 2 6

|  |  |   |  |  |  |   |  |
|--|--|---|--|--|--|---|--|
| 1. FOR<br>STATE<br>REGISTRAR   |  | 20. DATE KNOWN<br>OF DEATH  |  | 21. DATE<br>PRONOUNCED<br>DEAD   |  | 22. HOUR<br>2:05<br>A M   |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  | 2. DATE OF BIRTH<br>MONTH DAY YEAR  |  | 3. AGE (IN YEARS)<br>LAST BIRTHDAY   |  | 4. IF UNDER 1 YR.<br>MONTHS DAYS HOURS MIN  |  |
| FIRST MIDDLE LAST<br>ALLEN R. MONTGOMERY   |  | 5. DATE OF BIRTH<br>June 11, 1948   |  | 31 YRS.  |  |   |  |
| 6. SEX<br>male   |  | 7. RACE<br>white  |  | 8. BIRTHPLACE (STATE OR<br>FOREIGN COUNTRY)<br>Maryland  |  | 9. CITIZEN OF WHAT COUNTRY?<br>USA  |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore   |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>University Hospital (DOA) |  | 12. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 13. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.                         |  |
| 14. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>Maryland   |  | 13b. CITY OR TOWN<br>A. A. Baltimore  |  | 13c. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 13d. STREET ADDRESS<br>615 Wood St. Balto. Md. 21225                                |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Henry Frank Montgomery   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Gertude L. Burgess   |  | 16. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>Yes Vietnam  |  | 17. SOCIAL SECURITY NO.<br>213-54-3481  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Blunt injury to head<br>8147<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b) DUE TO, OR AS A CONSEQUENCE OF<br>(c) DUE TO, OR AS A CONSEQUENCE OF  |  | 19. INFORMANT<br>Mr. John H. Meyers, Same as above  |  | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH                                     |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).  |  |   |  |  |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |  |  |  | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input checked="" type="checkbox"/> OR<br>CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>1:12 PM 12-9-1979  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)<br>Pedestrian struck by auto.  |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)<br>street   |  | 21f. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Hitchie Hwy. no. Orchard St., Anne Arundel Md.   |  |   |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |  |   |  |  |  |   |  |
| ACTUAL<br>SIGNATURE<br>Virginia L. Dolan   |  | TITLE (SPECIFY)<br>Assistant MEDICAL EXAMINER   |  |  |  | DATE<br>SIGNED 12-10-79   |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT)   |  | ADDRESS   |  |  |  | 111 Penn St.  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)   |  | 23b. DATE   |  | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE  |  |
| Burial   |  | Dec. 13, 1979   |  | Cedar Hill Cemetery  |  | Baltimore, Maryland   |  |
| 24. FUNERAL DIRECTOR<br>NAME   |  | 25a. DATE REC'D. BY REGISTRAR   |  | 25b. REGISTRAR'S SIGNATURE   |  |   |  |
| McGully Funeral Home, 130 E. Font Ave. Balto. Md.  |  | DEC 11 1979   |  | L. J. McCready   |  |   |  |

57-1

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IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  | 7 9 3 0 4 2 7<br>REG. NO.   |  |   |  |
|---|--|---|--|---|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>LAURA Mae MONTGOMERY</b>  |  |   |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>DECEMBER 29, 1979</b>  |  | 2b. HOUR<br><b>05:46AM</b>  |  |
| 3 SEX<br><b>F</b>   |  | 4 RACE<br><b>B</b>  |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>3 30 00</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS<br><b>79 YRS.</b>   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Ga.</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Balto.</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>THE JOHNS HOPKINS HOSPITAL</b> |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)   |  |
| 13a. STATE<br><b>Md.</b>  |  | 13b. COUNTY   |  | 13c. CITY OR TOWN<br><b>Balto.</b>  |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>George Finley</b>   |  |   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>Rena Price</b>   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br><b>No</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>216-36-6787</b>  |  | 17. INFORMANT ADDRESS<br><b>Roy Patterson 159 Magothy Bridge Rd.</b>  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>436- Arystole</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>Probable Cerebrovascular Accident</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last   |  |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>5 minutes</b>  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><b>Seizure Disorder</b>  |  |   |  |   |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |   |  |
| 22a. I certify that (I) <u>this hospital</u> attended the deceased from <u>28 December</u> , 19 <u>77</u> , to <u>28 December</u> , 19 <u>79</u> , that (I) <u>we</u> last saw the deceased alive on <u>28 December</u> , 19 <u>79</u> , and that in <u>(my)</u> <u>(our)</u> opinion death occurred on the date and hour and from the causes stated above, <u>(I)</u> <u>(we)</u> <u>did</u> <u>(did not)</u> view the body after death. |  |   |  |   |  |   |  |
| 22b. SIGNATURE <b>James W. Hathorn</b>  |  |   |  | DEGREE <b>MD</b> ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br><b>12/28/79</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>JAMES W. HATHORN</b>  |  |   |  | 22e. ADDRESS<br><b>Johns Hopkins Hospital</b>   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>1/3/80</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Arbutus Mem. Pk.</b>   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><b>Arbutus, Md.</b>  |  |
| 24. FUNERAL DIRECTOR NAME<br><b>Wm C March F/H</b>  |  |   |  | ADDRESS<br><b>1101 E. North Ave.</b>  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>DEC 31 1979</b>   |  |
|   |  |   |  | 25b. REGISTRAR'S SIGNATURE<br><b>Robert M. Crady</b>  |  |   |  |

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UNITED STATES DEPARTMENT OF AGRICULTURE  
WASHINGTON, D. C.

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DEPARTMENT OF AGRICULTURE

OFFICE

*[Faint, mostly illegible handwritten text follows, appearing to be a memorandum or report.]*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after the death and retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after the death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  |  |  |  |  |   |  |
|--|--|---|--|--|--|--|--|---|--|
| 1. FOR STATE REGISTRAR   |  | 7 9 3 0 4 2 8<br>REG. NO.   |  | 1. DECEASED NAME (TYPE OR PRINT)<br>RICHARD EARL MONTGOMERY  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br>DECEMBER 31/1979   |  | 2b. HOUR P<br>5:30 M  |  |
| 3 SEX<br>Male  |  | 4 RACE<br>White   |  | 5 DATE OF BIRTH MONTH DAY YEAR<br>May 14, 1949   |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br>30 YRS   |  | 7 IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN  |  |
| 7a BIRTHPLACE (STATE OR FOREIGN)<br>District of Columbia   |  | 7b CITIZEN OF WHAT COUNTRY?<br>U. S. A.   |  | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD.                                      |  |   |  |
| 10 CITY OR TOWN OF DEATH<br>Baltimore  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>THE JOHNS HOPKINS HOSPITAL |  |  |  | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Assist. Mgr.                   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Service Station  |  |
| 13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13b STATE<br>Md.  |  |   |  | 13c CITY OR TOWN<br>Frederick  |  | 13d INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 14 STREET ADDRESS<br>Route 8, Box 57  |  |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br>Richard S. Montgomery   |  |   |  | 15 MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Edith Lorraine Zirkle  |  |  |  |   |  |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No  |  | 16b SOCIAL SECURITY NO<br>(IF YES, GIVE WAR OR DATES)<br>---  |  | 17 INFORMANT ADDRESS<br>Richard S. Montgomery-Receiver Rd.,<br>Frederick, Md. 21701  |  |  |  |   |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <u>CARDIAC ARREST FOLLOWING</u> 30 MIN<br>4241<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>AORTIC VALVE REPLACEMENT</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(c) <u>BACTERIAL ENDOCARDITIS</u><br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a): |  |   |  |  |  |  |  |   |  |
| 19a DATE OF OPERATION<br>12/17 & 12/26/79  |  | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED<br>Aortic Valve Disease   |  |  |  | 20a AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |  |  |  |   |  |
| 21d INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |   |  |
| 22a I certify that (1) (this hospital) attended the deceased from 12/15, 1979, to 12/31, 1979, that (1) (we) last saw the deceased alive on 12/31, 1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did) (did not) view the body after death.  |  |   |  |  |  |  |  |   |  |
| 22b SIGNATURE<br>Samuel Hassenbusch M.D.   |  |   |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>       |  | 22c DATE SIGNED<br>12/31/79  |  |   |  |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT)<br>SAMUEL HASSENBUSCH   |  |   |  | 22e ADDRESS<br>JOHNS HOPKINS HOSPITAL  |  |  |  |   |  |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial   |  | 23b DATE<br>1/5/80  |  | 23c NAME OF CEMETERY OR CREMATORY<br>Resurrection Cem.   |  | 23d LOCATION<br>(CITY OR TOWN) COUNTY STATE<br>Clinton (Pr. Geo's) Md.                         |  |   |  |
| 24 FUNERAL DIRECTOR<br>Richard A. Coleman-Upper Marlboro,<br>Funeral Home Maryland 20870:  |  |   |  | 25a DATE REC'D. BY REGISTRAR<br>JAN 7 1980   |  | 25b REGISTRAR'S SIGNATURE<br>Dorothy McCreedy  |  |   |  |

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DECEMBER 30, 1919

WASHINGTON

RECEIVED

20

May 14, 1919

White

White

WASHINGTON CITY

U. S. ...

U. S. ...

Washington, D. C.

THE ... HOSPITAL

Washington

Room 8, Box 17

Washington, D. C.

Washington, D. C.

Washington, D. C.

Washington, D. C. ...  
Washington, D. C. ...  
Washington, D. C. ...

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1/1/20 Washington, D. C.

Washington

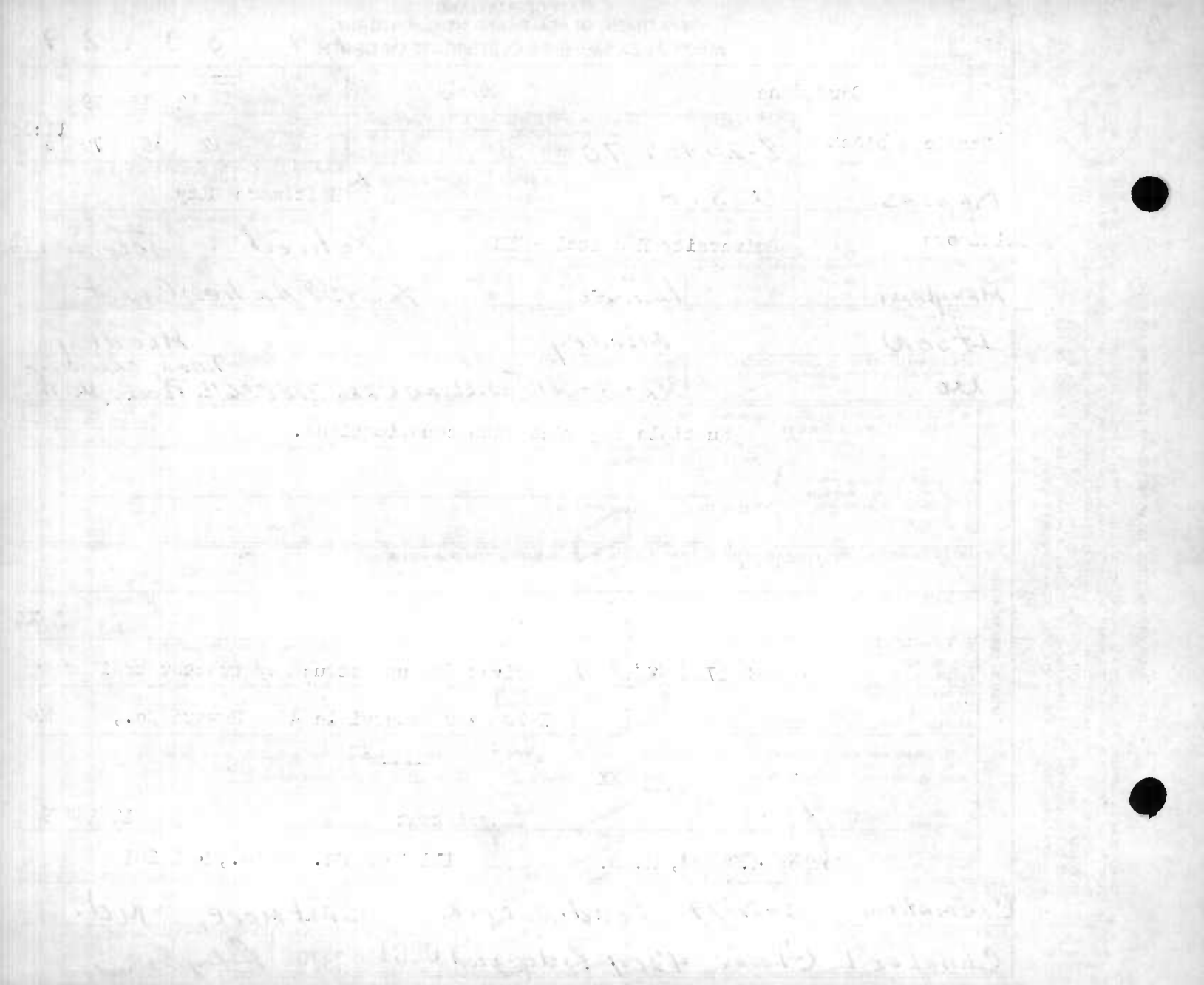
Washington, D. C. ...  
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Washington, D. C. ...

**NOT TO MEDICAL EXAMINER:** THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, THE MEDICAL EXAMINER MUST WRITE THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL HOME. GIVE PAGE 4 TO THE MEDICAL EXAMINER. GIVE PAGE 5 TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR RECORDS. **NOT TO FUNERAL DIRECTOR:** PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17  
(VR A15 ME (5))  
30M 7/73

| FOR<br>1- STATE REGISTRAR  |  |                         |  |  |  | DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH   |  |  |  |                  |  | 7 9 3 0 4 2 9   |  |  |  |   |  |   |  |  |  |
|--|--|-------------------------|--|--|--|--|--|--|--|------------------|--|---|--|--|--|---|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  |                         |  |  |  | FIRST                  MIDDLE                  LAST  |  |  |  |                  |  | 2d. DATE KNOWN OF DEATH ESTIMATED   |  |  |  | MONTH DAY YEAR HOUR   |  |   |  |  |  |
| Geraldine  |  |                         |  |  |  | Moody  |  |  |  |                  |  | <input checked="" type="checkbox"/> MONTH <input type="checkbox"/> DAY <input type="checkbox"/> YEAR  |  |  |  | 12 15 19 79   |  |   |  |  |  |
| 3. SEX<br><b>female</b>  |  | 4. RACE<br><b>black</b> |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>8-25-1909</b> |  | 6. AGE (IN YEARS)<br>LAST BIRTHDAY YRS.<br><b>70</b>   |  | IF UNDER 1 YR.<br>MONTHS DAYS HOURS MIN. |  | IF UNDER 24 HRS. |  | 7c. DATE PRONOUNCED DEAD<br>MONTH DAY YEAR<br><b>12 15 19 79</b>  |  |  |  | 11:35 a M   |  |   |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>KANSAS</b>   |  |                         |  |  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  |  |  |                  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b>                                   |  |   |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>altimore</b>   |  |                         |  |  |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>University Hospital -MIEM</b> |  |  |  |                  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Retired</b>   |  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Telephone Co</b>  |  |   |  |  |  |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE <b>MARYLAND</b> 13b. COUNTY <b>P.G.</b> 13c. CITY OR TOWN <b>LAUREL</b>   |  |                         |  |  |  |  |  |  |  |                  |  |   |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |   |  | 13e. STREET ADDRESS<br><b>3458 Andrew Court</b> |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Itson</b> <b>Moodey</b>   |  |                         |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Moodey</b>   |  |  |  |                  |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>No</b><br>16b. SOCIAL SECURITY NO. <b>382-22-3185</b>                                 |  |  |  | 17. INFORMANT ADDRESS<br><b>TULSA, OKLAHOMA</b><br><b>William Carr 328 E 36th Place, North.</b> |  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1 DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Multiple injuries with complications.</b><br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last:<br>(b) _____<br>(c) _____<br>PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).       |  |                         |  |  |  |  |  |  |  |                  |  |   |  |  |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  |                         |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |  |  |  |                  |  | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |  |  |   |  |   |  |  |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |  |                         |  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>12:17 AM 8/17 19 79</b>  |  |  |  |                  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)<br><b>driver of auto struck by tractor trailer</b>                            |  |  |  |   |  |   |  |  |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>  |  |                         |  |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)<br><b>road</b>   |  |  |  |                  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br><b>I 70 near Waterville Rd Howard Co., MD</b>  |  |  |  |   |  |   |  |  |  |
| 22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> and in my opinion |  |                         |  |  |  |  |  |  |  |                  |  |   |  |  |  |   |  |   |  |  |  |
| ACTUAL SIGNATURE <b>H.R. Guard</b> TITLE (SPECIFY) <b>Assistant</b> MEDICAL EXAMINER DATE SIGNED <b>12/16/79</b>   |  |                         |  |  |  |  |  |  |  |                  |  |   |  |  |  |   |  |   |  |  |  |
| EXAMINER'S NAME (TYPE OR PRINT) <b>Hormez R. Guard, M. D.</b> ADDRESS <b>111 Penn St. Balto., MD 21201</b>   |  |                         |  |  |  |  |  |  |  |                  |  |   |  |  |  |   |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Cremation</b>  |  |                         |  |  |  | 23b. DATE<br><b>12-21-79</b>   |  |  |  |                  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Loudon Park</b>  |  |  |  |   |  |   |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Charles L. Glover 4204 Ridgewood</b>  |  |                         |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>DEC 18 1979</b>  |  |  |  |                  |  | 25b. REGISTRAR'S SIGNATURE<br><b>Fitzgerald</b>   |  |  |  |   |  |   |  |  |  |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Md.</b>   |  |                         |  |  |  |  |  |  |  |                  |  |   |  |  |  |   |  |   |  |  |  |



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING," IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. GIVE PAGES 4 AND 5 TO THE CHIEF MEDICAL EXAMINER. GIVE PAGES 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100, 101, 102, 103, 104, 105, 106, 107, 108, 109, 110, 111, 112, 113, 114, 115, 116, 117, 118, 119, 120, 121, 122, 123, 124, 125, 126, 127, 128, 129, 130, 131, 132, 133, 134, 135, 136, 137, 138, 139, 140, 141, 142, 143, 144, 145, 146, 147, 148, 149, 150, 151, 152, 153, 154, 155, 156, 157, 158, 159, 160, 161, 162, 163, 164, 165, 166, 167, 168, 169, 170, 171, 172, 173, 174, 175, 176, 177, 178, 179, 180, 181, 182, 183, 184, 185, 186, 187, 188, 189, 190, 191, 192, 193, 194, 195, 196, 197, 198, 199, 200, 201, 202, 203, 204, 205, 206, 207, 208, 209, 210, 211, 212, 213, 214, 215, 216, 217, 218, 219, 220, 221, 222, 223, 224, 225, 226, 227, 228, 229, 230, 231, 232, 233, 234, 235, 236, 237, 238, 239, 240, 241, 242, 243, 244, 245, 246, 247, 248, 249, 250, 251, 252, 253, 254, 255, 256, 257, 258, 259, 260, 261, 262, 263, 264, 265, 266, 267, 268, 269, 270, 271, 272, 273, 274, 275, 276, 277, 278, 279, 280, 281, 282, 283, 284, 285, 286, 287, 288, 289, 290, 291, 292, 293, 294, 295, 296, 297, 298, 299, 300, 301, 302, 303, 304, 305, 306, 307, 308, 309, 310, 311, 312, 313, 314, 315, 316, 317, 318, 319, 320, 321, 322, 323, 324, 325, 326, 327, 328, 329, 330, 331, 332, 333, 334, 335, 336, 337, 338, 339, 340, 341, 342, 343, 344, 345, 346, 347, 348, 349, 350, 351, 352, 353, 354, 355, 356, 357, 358, 359, 360, 361, 362, 363, 364, 365, 366, 367, 368, 369, 370, 371, 372, 373, 374, 375, 376, 377, 378, 379, 380, 381, 382, 383, 384, 385, 386, 387, 388, 389, 390, 391, 392, 393, 394, 395, 396, 397, 398, 399, 400, 401, 402, 403, 404, 405, 406, 407, 408, 409, 410, 411, 412, 413, 414, 415, 416, 417, 418, 419, 420, 421, 422, 423, 424, 425, 426, 427, 428, 429, 430, 431, 432, 433, 434, 435, 436, 437, 438, 439, 440, 441, 442, 443, 444, 445, 446, 447, 448, 449, 450, 451, 452, 453, 454, 455, 456, 457, 458, 459, 460, 461, 462, 463, 464, 465, 466, 467, 468, 469, 470, 471, 472, 473, 474, 475, 476, 477, 478, 479, 480, 481, 482, 483, 484, 485, 486, 487, 488, 489, 490, 491, 492, 493, 494, 495, 496, 497, 498, 499, 500, 501, 502, 503, 504, 505, 506, 507, 508, 509, 510, 511, 512, 513, 514, 515, 516, 517, 518, 519, 520, 521, 522, 523, 524, 525, 526, 527, 528, 529, 530, 531, 532, 533, 534, 535, 536, 537, 538, 539, 540, 541, 542, 543, 544, 545, 546, 547, 548, 549, 550, 551, 552, 553, 554, 555, 556, 557, 558, 559, 560, 561, 562, 563, 564, 565, 566, 567, 568, 569, 570, 571, 572, 573, 574, 575, 576, 577, 578, 579, 580, 581, 582, 583, 584, 585, 586, 587, 588, 589, 590, 591, 592, 593, 594, 595, 596, 597, 598, 599, 600, 601, 602, 603, 604, 605, 606, 607, 608, 609, 610, 611, 612, 613, 614, 615, 616, 617, 618, 619, 620, 621, 622, 623, 624, 625, 626, 627, 628, 629, 630, 631, 632, 633, 634, 635, 636, 637, 638, 639, 640, 641, 642, 643, 644, 645, 646, 647, 648, 649, 650, 651, 652, 653, 654, 655, 656, 657, 658, 659, 660, 661, 662, 663, 664, 665, 666, 667, 668, 669, 670, 671, 672, 673, 674, 675, 676, 677, 678, 679, 680, 681, 682, 683, 684, 685, 686, 687, 688, 689, 690, 691, 692, 693, 694, 695, 696, 697, 698, 699, 700, 701, 702, 703, 704, 705, 706, 707, 708, 709, 710, 711, 712, 713, 714, 715, 716, 717, 718, 719, 720, 721, 722, 723, 724, 725, 726, 727, 728, 729, 730, 731, 732, 733, 734, 735, 736, 737, 738, 739, 740, 741, 742, 743, 744, 745, 746, 747, 748, 749, 750, 751, 752, 753, 754, 755, 756, 757, 758, 759, 760, 761, 762, 763, 764, 765, 766, 767, 768, 769, 770, 771, 772, 773, 774, 775, 776, 777, 778, 779, 780, 781, 782, 783, 784, 785, 786, 787, 788, 789, 790, 791, 792, 793, 794, 795, 796, 797, 798, 799, 800, 801, 802, 803, 804, 805, 806, 807, 808, 809, 810, 811, 812, 813, 814, 815, 816, 817, 818, 819, 820, 821, 822, 823, 824, 825, 826, 827, 828, 829, 830, 831, 832, 833, 834, 835, 836, 837, 838, 839, 840, 841, 842, 843, 844, 845, 846, 847, 848, 849, 850, 851, 852, 853, 854, 855, 856, 857, 858, 859, 860, 861, 862, 863, 864, 865, 866, 867, 868, 869, 870, 871, 872, 873, 874, 875, 876, 877, 878, 879, 880, 881, 882, 883, 884, 885, 886, 887, 888, 889, 890, 891, 892, 893, 894, 895, 896, 897, 898, 899, 900, 901, 902, 903, 904, 905, 906, 907, 908, 909, 910, 911, 912, 913, 914, 915, 916, 917, 918, 919, 920, 921, 922, 923, 924, 925, 926, 927, 928, 929, 930, 931, 932, 933, 934, 935, 936, 937, 938, 939, 940, 941, 942, 943, 944, 945, 946, 947, 948, 949, 950, 951, 952, 953, 954, 955, 956, 957, 958, 959, 960, 961, 962, 963, 964, 965, 966, 967, 968, 969, 970, 971, 972, 973, 974, 975, 976, 977, 978, 979, 980, 981, 982, 983, 984, 985, 986, 987, 988, 989, 990, 991, 992, 993, 994, 995, 996, 997, 998, 999, 1000.

| #8, File #539 1/11/80 kam   |  |             |  |                   |  |                          |  |                      |  | STATE OF MARYLAND                               |  |                          |  |          |                                      |  |  |  |  |
|---|--|-------------|--|-------------------|--|--------------------------|--|----------------------|--|---|--|--------------------------|--|----------|--------------------------------------|--|--|--|--|
| 1- STATE REGISTRAR  |  |             |  |                   |  |                          |  |                      |  | DEPARTMENT OF HEALTH AND MENTAL HYGIENE         |  |                          |  |          |                                      |  |  |  |  |
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH   |  |             |  |                   |  |                          |  |                      |  | REG. NO. 30430                                  |  |                          |  |          |                                      |  |  |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |  |             |  |                   | FIRST MIDDLE LAST  |                          |  |                      |  | 2a. DATE KNOWN OF DEATH                         |  |                          |  |          | 2b. HOUR                             |  |  |  |  |
| Edward Earl Moore   |  |             |  |                   |  |                          |  |                      |  | 12 7 19 79                                      |  |                          |  |          | 7:30 P M                             |  |  |  |  |
| 3. SEX  |  | 4. RACE     |  | 5. DATE OF BIRTH  |  | 6. AGE (IN YEARS)        |  | IF UNDER 1 YR.       |  | IF UNDER 24 HRS.                                |  | 2c. DATE PRONOUNCED DEAD |  | 2d. HOUR |                                      |  |  |  |  |
| Male  |  | White       |  | Feb. 26, 1948     |  | 31 YRS.                  |  |                      |  |   |  | 12 7 19 79               |  | 7:30 P M |                                      |  |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  |             |  |                   | 7b. CITIZEN OF WHAT COUNTRY?                             |                          |  |                      |  | 8. MARRIED                                      |  |                          |  |          | 9. BALTIMORE CITY OR COUNTY OF DEATH |  |  |  |  |
| Illinois  |  |             |  |                   | U.S.A.   |                          |  |                      |  | NEVER MARRIED                                   |  |                          |  |          | Baltimore City, MD.                  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH   |  |             |  |                   | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION |                          |  |                      |  | 12a. USUAL OCCUPATION                           |  |                          |  |          | 12b. KIND OF BUSINESS OR INDUSTRY    |  |  |  |  |
| Baltimore   |  |             |  |                   | Maryland General Hospital                                |                          |  |                      |  | Merchant Marine-Engineer                        |  |                          |  |          |                                      |  |  |  |  |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  |             |  |                   |  |                          |  |                      |  |   |  |                          |  |          |                                      |  |  |  |  |
| 13a. STATE  |  | 13b. COUNTY |  | 13c. CITY OR TOWN |  | 13d. INSIDE CITY LIMITS? |  | 13e. STREET ADDRESS  |  |   |  |                          |  |          |                                      |  |  |  |  |
| Maryland  |  | Baltimore   |  | Baltimore         |  | YES                      |  | 315 East 33rd Street |  |   |  |                          |  |          |                                      |  |  |  |  |
| 14. FATHER'S NAME   |  |             |  |                   | 15. MOTHER'S MAIDEN NAME                                 |                          |  |                      |  |   |  |                          |  |          |                                      |  |  |  |  |
| Richard L. Moore  |  |             |  |                   | Beverly J. Heston  |                          |  |                      |  |   |  |                          |  |          |                                      |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?  |  |             |  |                   | 16b. SOCIAL SECURITY NO.                                 |                          |  |                      |  | 17. INFORMANT                                   |  |                          |  |          | 18. CAUSE OF DEATH                   |  |  |  |  |
| No  |  |             |  |                   | 340-40-4051  |                          |  |                      |  | Beverly Hubbard                                 |  |                          |  |          | Blunt injury to head                 |  |  |  |  |
| PART 1 DEATH WAS CAUSED BY:   |  |             |  |                   |  |                          |  |                      |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH    |  |                          |  |          |                                      |  |  |  |  |
| IMMEDIATE CAUSE (a)   |  |             |  |                   |  |                          |  |                      |  |   |  |                          |  |          |                                      |  |  |  |  |
| 8/52  |  |             |  |                   |  |                          |  |                      |  |   |  |                          |  |          |                                      |  |  |  |  |
| Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.                                       |  |             |  |                   |  |                          |  |                      |  |   |  |                          |  |          |                                      |  |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF  |  |             |  |                   |  |                          |  |                      |  |   |  |                          |  |          |                                      |  |  |  |  |
| (b)   |  |             |  |                   |  |                          |  |                      |  |   |  |                          |  |          |                                      |  |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF  |  |             |  |                   |  |                          |  |                      |  |   |  |                          |  |          |                                      |  |  |  |  |
| (c)   |  |             |  |                   |  |                          |  |                      |  |   |  |                          |  |          |                                      |  |  |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). |  |             |  |                   |  |                          |  |                      |  |   |  |                          |  |          |                                      |  |  |  |  |
| 19a. DATE OF OPERATION  |  |             |  |                   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?        |                          |  |                      |  | 20. AUTOPSY?                                    |  |                          |  |          |                                      |  |  |  |  |
|   |  |             |  |                   |  |                          |  |                      |  | YES   |  |                          |  |          |                                      |  |  |  |  |
| 21a. EXTERNAL CAUSE WAS   |  |             |  |                   | 21b. TIME OF INJURY                                      |                          |  |                      |  | 21c. HOW INJURY OCCURRED                        |  |                          |  |          |                                      |  |  |  |  |
| UNDERLYING  |  |             |  |                   | 7:10 P.M. 12 7 19 79                                     |                          |  |                      |  | Driver of motorcycle/fixed object impact        |  |                          |  |          |                                      |  |  |  |  |
| CONTRIBUTING  |  |             |  |                   |  |                          |  |                      |  |   |  |                          |  |          |                                      |  |  |  |  |
| 21d. INJURY OCCURRED  |  |             |  |                   | 21e. PLACE OF INJURY                                     |                          |  |                      |  | 21f. LOCATION                                   |  |                          |  |          |                                      |  |  |  |  |
| WHILE AT WORK   |  |             |  |                   | street   |                          |  |                      |  | 800 Blk. N. Calvert Street, Baltimore City, Md. |  |                          |  |          |                                      |  |  |  |  |
| 22a. I certify that I took charge of the remains described above, held an   |  |             |  |                   |  |                          |  |                      |  | Autopsy   |  |                          |  |          |                                      |  |  |  |  |
| death resulted from:  |  |             |  |                   |  |                          |  |                      |  | Inspection                                      |  |                          |  |          |                                      |  |  |  |  |
| Natural causes  |  |             |  |                   |  |                          |  |                      |  | Inquiry   |  |                          |  |          |                                      |  |  |  |  |
| Accident  |  |             |  |                   |  |                          |  |                      |  | and in my opinion                               |  |                          |  |          |                                      |  |  |  |  |
| Suicide   |  |             |  |                   |  |                          |  |                      |  |   |  |                          |  |          |                                      |  |  |  |  |
| Homicide  |  |             |  |                   |  |                          |  |                      |  |   |  |                          |  |          |                                      |  |  |  |  |
| Undetermined manner   |  |             |  |                   |  |                          |  |                      |  |   |  |                          |  |          |                                      |  |  |  |  |
| ACTUAL SIGNATURE  |  |             |  |                   | TITLE (SPECIFY)  |                          |  |                      |  | DATE SIGNED                                     |  |                          |  |          |                                      |  |  |  |  |
| Virginia L. Dolan, M.D.   |  |             |  |                   | Assistant  |                          |  |                      |  | 12/8/79   |  |                          |  |          |                                      |  |  |  |  |
| EXAMINER'S NAME   |  |             |  |                   | ADDRESS  |                          |  |                      |  |   |  |                          |  |          |                                      |  |  |  |  |
| Virginia L. Dolan, M.D.   |  |             |  |                   | 111 Penn Street  |                          |  |                      |  |   |  |                          |  |          |                                      |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL   |  |             |  |                   | 23b. DATE  |                          |  |                      |  | 23c. NAME OF CEMETERY OR CREMATORY              |  |                          |  |          |                                      |  |  |  |  |
| Cremation   |  |             |  |                   | 12-12-79   |                          |  |                      |  | Greenmount                                      |  |                          |  |          |                                      |  |  |  |  |
| 24. FUNERAL DIRECTOR  |  |             |  |                   | 25a. DATE REC'D. BY REGISTRAR                            |                          |  |                      |  | 25b. REGISTRAR'S SIGNATURE                      |  |                          |  |          |                                      |  |  |  |  |
| Leonard J. Ruck, Inc.   |  |             |  |                   | 5305 Harford Rd. Balt. Md.                               |                          |  |                      |  | DEC 12 1979                                     |  |                          |  |          |                                      |  |  |  |  |







TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 48 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |   |  |   |   |   |  |   | 79 30431<br>REG. NO.                         |  |                      |  |
|---|--|--|---|--|---|---|---|--|---|--|--|----------------------|--|
| 1. FOR STATE REGISTRAR  |  |  |   |  | 1. DECEASED NAME (TYPE OR PRINT)  |   |   |  |   | 2a. DATE OF DEATH MONTH DAY YEAR             |  | 2b. HOUR P. M.       |  |
| FLORENCE PARRISH MOORE  |  |  |   |  |   |   |   |  |   | 12-16-79                                     |  | 9:30 P.              |  |
| 3. SEX  |  | 4. RACE  |   | 5. DATE OF BIRTH MONTH DAY YEAR  |   | 6. AGE (IN YEARS LAST BIRTHDAY)                               |   | IF UNDER 1 YEAR MONTHS DAYS                                |   | IF UNDER 24 HRS. HOURS MIN.                  |  |                      |  |
| Female  |  | white  |   | Aug. 30, 1897  |   | 82 YRS.   |   |  |   |  |  |                      |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  | 7b. CITIZEN OF WHAT COUNTRY?   |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH                          |   |  |   |  |  |                      |  |
| Ky.   |  | U.S.A.   |   |  |   | Baltimore MD.   |   |  |   |  |  |                      |  |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |   |  |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) |   | 12b. KIND OF BUSINESS OR INDUSTRY                          |   |  |  |                      |  |
| Baltimore   |  | Sinai Hosp.  |   |  |   | housewife   |   | home   |   |  |  |                      |  |
| 13a. STATE  |  |  |   |  | 13b. COUNTY   |   | 13c. CITY OR TOWN   |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                            |  |  | 13e. STREET ADDRESS  |  |
| Maryland  |  |  |   |  | Baltimore   |   | Catonsville   |  |   |  |  | 1105 S. Rolling Road |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST   |  |  |   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST  |   |   |  |   |  |  |                      |  |
| George W. Parrish   |  |  |   |  | Bena Weible   |   |   |  |   |  |  |                      |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)   |  |  |   |  | 16b. SOCIAL SECURITY NO.  |   | 17. INFORMANT ADDRESS   |  |   |  |  |                      |  |
| no  |  |  |   |  | 324 20 3716   |   | Robert W. Moore 1105 S. Rolling Road Catonsville, Maryland 21228                  |  |   |  |  |                      |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Sepsis.</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>0389</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c)   |  |  |   |  |   |   |   |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |                      |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)  |  |  |   |  |   |   |   |  |   |  |  |                      |  |
| 19a. DATE OF OPERATION  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                    |  |   |   | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |                      |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19                |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |   |   |  |   |  |  |                      |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |   |   |  |   |  |  |                      |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |   |  |   |   |   |  |   |  |  |                      |  |
| 22b. SIGNATURE D.S. PATEL 9461  |  |  |   |  | DEGREE MD. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |   |   |  |   | 22c. DATE SIGNED 12-16-79                    |  |                      |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) D.S. PATEL.   |  |  |   |  | 22e. ADDRESS SINAI HOSPITAL.  |   |   |  |   |  |  |                      |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) burial  |  |  | 23b. DATE 12/19/79  |  | 23c. NAME OF CEMETERY OR CREMATORY Arlington National   |   |   | 23d. LOCATION CITY OR TOWN COUNTY STATE Arlington Virginia |   |  |  |                      |  |
| 24. FUNERAL DIRECTOR NAME SLACK Funeral Home, Ellicott City, Maryland 21043   |  |  |   |  | 25a. DATE REC'D. BY REGISTRAR DEC 20 1979   |   | 25b. REGISTRAR SIGNATURE <i>Estey/Hubert</i>                                      |  |   |  |  |                      |  |

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. GIVE PAGE 4 TO THE CHIEF MEDICAL EXAMINER. GIVE PAGES 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100, 101, 102, 103, 104, 105, 106, 107, 108, 109, 110, 111, 112, 113, 114, 115, 116, 117, 118, 119, 120, 121, 122, 123, 124, 125, 126, 127, 128, 129, 130, 131, 132, 133, 134, 135, 136, 137, 138, 139, 140, 141, 142, 143, 144, 145, 146, 147, 148, 149, 150, 151, 152, 153, 154, 155, 156, 157, 158, 159, 160, 161, 162, 163, 164, 165, 166, 167, 168, 169, 170, 171, 172, 173, 174, 175, 176, 177, 178, 179, 180, 181, 182, 183, 184, 185, 186, 187, 188, 189, 190, 191, 192, 193, 194, 195, 196, 197, 198, 199, 200, 201, 202, 203, 204, 205, 206, 207, 208, 209, 210, 211, 212, 213, 214, 215, 216, 217, 218, 219, 220, 221, 222, 223, 224, 225, 226, 227, 228, 229, 230, 231, 232, 233, 234, 235, 236, 237, 238, 239, 240, 241, 242, 243, 244, 245, 246, 247, 248, 249, 250, 251, 252, 253, 254, 255, 256, 257, 258, 259, 260, 261, 262, 263, 264, 265, 266, 267, 268, 269, 270, 271, 272, 273, 274, 275, 276, 277, 278, 279, 280, 281, 282, 283, 284, 285, 286, 287, 288, 289, 290, 291, 292, 293, 294, 295, 296, 297, 298, 299, 300, 301, 302, 303, 304, 305, 306, 307, 308, 309, 310, 311, 312, 313, 314, 315, 316, 317, 318, 319, 320, 321, 322, 323, 324, 325, 326, 327, 328, 329, 330, 331, 332, 333, 334, 335, 336, 337, 338, 339, 340, 341, 342, 343, 344, 345, 346, 347, 348, 349, 350, 351, 352, 353, 354, 355, 356, 357, 358, 359, 360, 361, 362, 363, 364, 365, 366, 367, 368, 369, 370, 371, 372, 373, 374, 375, 376, 377, 378, 379, 380, 381, 382, 383, 384, 385, 386, 387, 388, 389, 390, 391, 392, 393, 394, 395, 396, 397, 398, 399, 400, 401, 402, 403, 404, 405, 406, 407, 408, 409, 410, 411, 412, 413, 414, 415, 416, 417, 418, 419, 420, 421, 422, 423, 424, 425, 426, 427, 428, 429, 430, 431, 432, 433, 434, 435, 436, 437, 438, 439, 440, 441, 442, 443, 444, 445, 446, 447, 448, 449, 450, 451, 452, 453, 454, 455, 456, 457, 458, 459, 460, 461, 462, 463, 464, 465, 466, 467, 468, 469, 470, 471, 472, 473, 474, 475, 476, 477, 478, 479, 480, 481, 482, 483, 484, 485, 486, 487, 488, 489, 490, 491, 492, 493, 494, 495, 496, 497, 498, 499, 500, 501, 502, 503, 504, 505, 506, 507, 508, 509, 510, 511, 512, 513, 514, 515, 516, 517, 518, 519, 520, 521, 522, 523, 524, 525, 526, 527, 528, 529, 530, 531, 532, 533, 534, 535, 536, 537, 538, 539, 540, 541, 542, 543, 544, 545, 546, 547, 548, 549, 550, 551, 552, 553, 554, 555, 556, 557, 558, 559, 560, 561, 562, 563, 564, 565, 566, 567, 568, 569, 570, 571, 572, 573, 574, 575, 576, 577, 578, 579, 580, 581, 582, 583, 584, 585, 586, 587, 588, 589, 590, 591, 592, 593, 594, 595, 596, 597, 598, 599, 600, 601, 602, 603, 604, 605, 606, 607, 608, 609, 610, 611, 612, 613, 614, 615, 616, 617, 618, 619, 620, 621, 622, 623, 624, 625, 626, 627, 628, 629, 630, 631, 632, 633, 634, 635, 636, 637, 638, 639, 640, 641, 642, 643, 644, 645, 646, 647, 648, 649, 650, 651, 652, 653, 654, 655, 656, 657, 658, 659, 660, 661, 662, 663, 664, 665, 666, 667, 668, 669, 670, 671, 672, 673, 674, 675, 676, 677, 678, 679, 680, 681, 682, 683, 684, 685, 686, 687, 688, 689, 690, 691, 692, 693, 694, 695, 696, 697, 698, 699, 700, 701, 702, 703, 704, 705, 706, 707, 708, 709, 710, 711, 712, 713, 714, 715, 716, 717, 718, 719, 720, 721, 722, 723, 724, 725, 726, 727, 728, 729, 730, 731, 732, 733, 734, 735, 736, 737, 738, 739, 740, 741, 742, 743, 744, 745, 746, 747, 748, 749, 750, 751, 752, 753, 754, 755, 756, 757, 758, 759, 760, 761, 762, 763, 764, 765, 766, 767, 768, 769, 770, 771, 772, 773, 774, 775, 776, 777, 778, 779, 780, 781, 782, 783, 784, 785, 786, 787, 788, 789, 790, 791, 792, 793, 794, 795, 796, 797, 798, 799, 800, 801, 802, 803, 804, 805, 806, 807, 808, 809, 810, 811, 812, 813, 814, 815, 816, 817, 818, 819, 820, 821, 822, 823, 824, 825, 826, 827, 828, 829, 830, 831, 832, 833, 834, 835, 836, 837, 838, 839, 840, 841, 842, 843, 844, 845, 846, 847, 848, 849, 850, 851, 852, 853, 854, 855, 856, 857, 858, 859, 860, 861, 862, 863, 864, 865, 866, 867, 868, 869, 870, 871, 872, 873, 874, 875, 876, 877, 878, 879, 880, 881, 882, 883, 884, 885, 886, 887, 888, 889, 890, 891, 892, 893, 894, 895, 896, 897, 898, 899, 900, 901, 902, 903, 904, 905, 906, 907, 908, 909, 910, 911, 912, 913, 914, 915, 916, 917, 918, 919, 920, 921, 922, 923, 924, 925, 926, 927, 928, 929, 930, 931, 932, 933, 934, 935, 936, 937, 938, 939, 940, 941, 942, 943, 944, 945, 946, 947, 948, 949, 950, 951, 952, 953, 954, 955, 956, 957, 958, 959, 960, 961, 962, 963, 964, 965, 966, 967, 968, 969, 970, 971, 972, 973, 974, 975, 976, 977, 978, 979, 980, 981, 982, 983, 984, 985, 986, 987, 988, 989, 990, 991, 992, 993, 994, 995, 996, 997, 998, 999, 1000.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |  |                      |  |   |  |   |  |  |  | REG. NO. 3 0 4 3 2   |  |
|--|--|----------------------|--|---|--|---|--|--|--|--|--|
| 1. FOR STATE REGISTRAR   |  |                      |  |   |  |   |  |  |  |  |  |
| 1. DECEASED NAME (TYPE OR PRINT) <b>Herbert A. Moore</b>   |  |                      |  |   | 2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH <b>11</b> DAY <b>26</b> YEAR <b>1979</b> |   |  |  |  | 2b. HOUR <b>M</b>  |  |
| 3. SEX <b>Male</b>   |  | 4. RACE <b>Black</b> |  | 5. DATE OF BIRTH MONTH <b>Mar</b> DAY <b>27</b> YEAR <b>1936</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY) <b>43</b> YRS.                                |  | IF UNDER 24 HRS. MONTHS DAYS HOURS MIN.  |  | 2c. DATE PRONOUNCED DEAD <b>Nov. 11 26 1979</b>                                  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>  |  |                      |  | 7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>  |  |   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City, MD.</b>                  |  |
| 10. CITY OR TOWN OF DEATH <b>Baltimore</b>   |  |                      |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>2777 W. North Avenue</b> |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Supervisor</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY <b>Univ. of Md.</b>                            |  |
| 13a. STATE <b>Maryland</b>   |  |                      |  | 13b. COUNTY   |  | 13c. CITY OR TOWN <b>Baltimore</b>  |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 13e. STREET ADDRESS <b>2777 West North Avenue</b>                                |  |
| 14. FATHER'S NAME FIRST <b>James</b> MIDDLE <b>William</b> LAST <b>Moore</b>   |  |                      |  |   |  | 15. MOTHER'S MAIDEN NAME FIRST <b>Lucille</b> MIDDLE <b>Braxton</b> LAST      |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>NO</b>   |  |                      |  | 16b. SOCIAL SECURITY NO. <b>213-34-2129</b>   |  | 17. INFORMANT ADDRESS <b>Geraldine Miller/3209 Phelps Lane</b>                |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br><b>2765</b> IMMEDIATE CAUSE (a) <b>Hypernatremia secondary to dehydration</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b)<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH             |  |                      |  |   |  |   |  |  |  |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).  |  |                      |  |   |  |   |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  |                      |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |  |   |  |  |  | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |  |                      |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) |  |  |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK  |  |                      |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                |  |  |  |  |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |  |                      |  |   |  |   |  |  |  |  |  |
| ACTUAL SIGNATURE <b>Virginia L. Dolan</b>  |  |                      |  | TITLE (SPECIFY) <b>Assistant</b>  |  |   |  | DATE SIGNED <b>11/27/79</b>  |  |  |  |
| EXAMINER'S NAME (TYPE OR PRINT) <b>Virginia L. Dolan, M.D.</b>   |  |                      |  | ADDRESS <b>111 Penn Street</b>  |  |   |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>  |  |                      |  | 23b. DATE <b>12/01/79</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY <b>Westview Mem. Park</b>                  |  |  |  | 23d. LOCATION CITY OR TOWN <b>Balto.</b> COUNTY <b>Balto.</b> STATE <b>Md.</b>   |  |
| 24. FUNERAL DIRECTOR NAME <b>Marshall W Jones Jr</b>   |  |                      |  | ADDRESS <b>4101 Edmondson Ave</b>   |  |   |  | 25a. DATE REC'D. BY REGISTRAR <b>DEC 7 1979</b>  |  | 25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>                                    |  |

BP

SECRET

SECRET

1. The purpose of this document is to provide information regarding the activities of the [redacted] organization.

2. The information contained herein is classified as [redacted] and is to be controlled in accordance with the [redacted] policy.

CONFIDENTIAL

SECRET

3. The [redacted] organization is a [redacted] organization that has been active in the [redacted] area.

4. The [redacted] organization has been active in the [redacted] area since [redacted] and has been involved in [redacted] activities.

5. The [redacted] organization has been active in the [redacted] area since [redacted] and has been involved in [redacted] activities.

6. The [redacted] organization has been active in the [redacted] area since [redacted] and has been involved in [redacted] activities.

7. The [redacted] organization has been active in the [redacted] area since [redacted] and has been involved in [redacted] activities.

8. The [redacted] organization has been active in the [redacted] area since [redacted] and has been involved in [redacted] activities.

9. The [redacted] organization has been active in the [redacted] area since [redacted] and has been involved in [redacted] activities.

10. The [redacted] organization has been active in the [redacted] area since [redacted] and has been involved in [redacted] activities.

11. The [redacted] organization has been active in the [redacted] area since [redacted] and has been involved in [redacted] activities.

12. The [redacted] organization has been active in the [redacted] area since [redacted] and has been involved in [redacted] activities.

13. The [redacted] organization has been active in the [redacted] area since [redacted] and has been involved in [redacted] activities.

14. The [redacted] organization has been active in the [redacted] area since [redacted] and has been involved in [redacted] activities.

FOR  
1 - STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH7 9 3 0 4 3 3  
REG. NO.

|   |  |  |  |   |   |  |   |  |
|---|--|--|--|---|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <u>Moore</u> <u>Jean</u> <u>Elizabeth</u>   |  |  | 2a. DATE OF DEATH MONTH <u>Dec</u> DAY <u>23</u> YEAR <u>'79</u> |   |   | 2b. HOUR <u>10:05</u> P <u>M</u>                               |   |  |
| 3. SEX <u>F</u>   |  | 4. RACE <u>W</u>   |  | 5. DATE OF BIRTH MONTH <u>4</u> DAY <u>30</u> YEAR <u>28</u>  |   | 6. AGE (IN YEARS LAST BIRTHDAY) <u>51</u> YRS.                 |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>N. Carolina</u>  |  | 7b. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>   |   | 9. BALTIMORE CITY OR COUNTY OF DEATH <u>Baltimore City</u> MD. |   |  |
| 10. CITY OR TOWN OF DEATH <u>Baltimore Md.</u>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>1001 St. Paul St.</u> |  |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE) <u>L.P.N.</u>    |  | 12b. KIND OF BUSINESS OR INDUSTRY <u>Nursing</u>  |  |
| 13a. STATE <u>MD.</u>   |  |  |  | 13b. COUNTY <u>Baltimore</u>  |   | 13c. CITY OR TOWN <u>Balto.</u>                                |   |  |
| 14. FATHER'S NAME FIRST <u>399</u> MIDDLE <u>300</u> LAST <u>1</u>  |  |  |  | 15. MOTHER'S MAIDEN NAME FIRST <u>300</u> MIDDLE <u>1</u> LAST <u>1</u>   |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <u>Unkn.</u>   |  | 16b. SOCIAL SECURITY NO. <u>231-36-2456</u>  |  | 17. INFORMANT ADDRESS   |   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <u>Arteriosclerosis</u> <u>4409</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>several</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(c) <u>months</u><br>DUE TO, OR AS A CONSEQUENCE OF |  |  |  |   |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <u>Varicosities both Legs</u> <u>several years</u>  |  |  |  |   |   |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |   |  |   |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |   |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>May 18</u> , 19 <u>77</u> , to <u>Dec 29</u> , 19 <u>79</u> , that (I) (we) last saw the deceased alive on <u>12-18</u> , 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.             |  |  |  |   |   |  |   |  |
| 22b. SIGNATURE <u>E. Ellsworth Cook</u>   |  |  |  | DEGREE <u>M.D.</u> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |   |  | 22c. DATE SIGNED <u>12-26-79</u>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>E. Ellsworth Cook</u>  |  |  |  | 22e. ADDRESS <u>2431 Maryland Ave. Balto. Md.</u>   |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Removal</u>  |  | 23b. DATE <u>12/23/79</u>  |  | 23c. NAME OF CEMETERY OR CREMATORY  |   | 23d. LOCATION CITY OR TOWN COUNTY STATE                        |   |  |
| 24. FUNERAL DIRECTOR NAME <u>Anatomy Board</u> ADDRESS <u>Balto., Md.</u>   |  |  |  | 25a. DATE REC'D. BY REGISTRAR <u>1 JAN 8 1980</u>   |   | 25b. REGISTRAR'S SIGNATURE <u>Lifsey McCreedy</u>              |   |  |





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| FOR STATE REGISTRAR   |  |   |  | STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  | REG. NO. 7 9 3 0 4 3 4  |                                   |  |  |
|---|--|---|--|---|--|--|--|---|-----------------------------------|--|--|
| 1. DECEASED NAME (TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>RUTH JANE MOORE  |  |   |  |   |  | 2a. DATE OF DEATH MONTH DAY YEAR<br>12/22/79                                       |  |   |                                   | 2b. HOUR<br>11:28 PM                         |  |
| 3. SEX<br>F   |  | 4. RACE<br>B  |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>4 1 - 1940   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>39 YRS  |  | 7. IF UNDER 1 YEAR MONTHS DAYS  |                                   | 7. IF UNDER 24 HRS. HOURS MIN.               |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>VA   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.                         |  |   |                                   |  |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>LUTHERAN Hospital |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>HOMEMAKER at home |  |   | 12b. KIND OF BUSINESS OR INDUSTRY |  |  |
| 13a. STATE<br>MD  |  |   |  |   |  | 13b. COUNTY<br>Baltimore   |  | 13c. CITY OR TOWN<br>Baltimore  |                                   | 13d. STREET ADDRESS<br>1601 Spray Ct         |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>FREDERICK MOORE  |  |   |  |   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>MARILYN HOWARD                       |  |   |                                   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>no   |  | 16b. SOCIAL SECURITY NO.<br>220-36-0741   |  | 17. INFORMANT ADDRESS<br>MARILYN HOWARD MOORE   |  |  |  |   |                                   |  |  |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cardiac arrest</u><br><u>2780</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>myocardial Infarction</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) <u>morbid obesity</u>            |  |   |  |   |  |  |  |   |                                   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><u>Diabetes mellitus</u>   |  |   |  |   |  |  |  |   |                                   |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |                                   |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |   |                                   |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |  |  |   |                                   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>12/20</u> , 19 <u>79</u> , to <u>12/29</u> , 19 <u>79</u> , that (I) (we) lost saw the deceased alive on <u>12/22</u> , 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. |  |   |  |   |  |  |  |   |                                   |  |  |
| 22b. SIGNATURE <u>Mary K. Krummold</u> DEGREE <u>MD</u>   |  |   |  |   |  | 22c. DATE SIGNED<br>12/22/79   |  | 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>MOSES GEBREMARIAM  |                                   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial   |  | 23b. DATE<br>12/28/79   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Fleming Pk  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br>Suisun Co VA                            |  |   |                                   |  |  |
| 24. FUNERAL DIRECTOR<br>M. Hays 638 N. G. Moore St  |  |   |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br>DEC 24 1979                                       |  | 25b. REGISTRAR'S SIGNATURE<br>Fitzroy McCreedy  |                                   |  |  |



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My dear Sir,  
I have the honor to acknowledge the receipt of your letter of the 10th inst. in relation to the above matter.

I am sorry to hear that you are not satisfied with the result of the examination of the papers in your possession. I have, however, no objection to your making such further investigation as you may deem proper.

I am, Sir, very respectfully,  
Yours,  
J. H. [Signature]

Very truly,  
J. H. [Signature]



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR OR TO FUNERAL DIRECTOR. PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITH PAGES 3 AND 4 AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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FOR  
1- STATE  
REGISTRAR

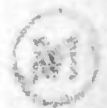
STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

9 30435

|   |         |   |  |   |  |  |  |   |  |  |  |   |  |
|---|---------|---|--|---|--|--|--|---|--|--|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |         | FIRST   |  | MIDDLE  |  | LAST   |  | 2a. DATE KNOWN OF DEATH   |  |  |  | 2b. HOUR  |  |
| Shirley Hyman Moore   |         |   |  |   |  |  |  | X MONTH DAY YEAR<br>12 21 19 79   |  |  |  | M<br>8:15P  |  |
| 3. SEX  | 4. RACE | 5. DATE OF BIRTH  |  | 6. AGE (IN YEARS LAST BIRTHDAY)                             |  | IF UNDER 1 YR.   |  | IF UNDER 24 HRS.  |  | 2c. DATE PRONOUNCED DEAD   |  | 2d. HOUR  |  |
| Male  | Black   | 4 21 06   |  | 73 YRS.   |  |  |  |   |  | 12 21 19 79  |  | M   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |         | 7b. CITIZEN OF WHAT COUNTRY?  |  |   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH  |  |  |  |   |  |
| VIRGINIA  |         | U. S. A.  |  |   |  |  |  | Baltimore City, MD.   |  |  |  |   |  |
| 10. CITY OR TOWN OF DEATH   |         | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |  |   |  | 12b. KIND OF BUSINESS OR INDUSTRY                                      |  |   |  |
| Baltimore City  |         | 2647 Loyola Southway  |  |   |  | Gov. Empl.   |  |   |  |  |  |   |  |
| 13a. STATE  |         | 13b. COUNTY   |  | 13c. CITY OR TOWN   |  | 13d. INSIDE CITY LIMITS?   |  | 13e. STREET ADDRESS   |  |  |  |   |  |
| MD.   |         |   |  | BALTO   |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 2647 Loyola Southway  |  |  |  |   |  |
| 14. FATHER'S NAME   |         |   |  | 15. MOTHER'S MAIDEN NAME                                    |  |  |  |   |  |  |  |   |  |
| FIRST MIDDLE LAST<br>WALTER MOORE   |         |   |  | FIRST MIDDLE LAST<br>MARTHA HAYMAN                          |  |  |  |   |  |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)  |         |   |  | 16b. SOCIAL SECURITY NO.                                    |  | 17. INFORMANT  |  |   |  | ADDRESS  |  |   |  |
|   |         |   |  |   |  | ETHEL M. PORTER FIELD (SISTER)   |  |   |  |  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Arteriosclerotic cardiovascular disease</u><br>4292<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____   |         |   |  |   |  |  |  |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                        |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).   |         |   |  |   |  |  |  |   |  |  |  |   |  |
| 19a. DATE OF OPERATION  |         |   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?           |  |  |  |   |  |  |  | 20. AUTOPSY?  |  |
|   |         |   |  |   |  |  |  |   |  |  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |         |   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR                |  |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) |  |  |  |   |  |
|   |         |   |  | P.M. 19   |  |  |  |   |  |  |  |   |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |         |   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) |  |  |  | 21f. LOCATION   |  |  |  |   |  |
|   |         |   |  |   |  |  |  | CITY OR TOWN COUNTY STATE   |  |  |  |   |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . |         |   |  |   |  |  |  |   |  |  |  |   |  |
| ACTUAL SIGNATURE <u>Virginia L. Dolan</u>   |         |   |  | TITLE (SPECIFY) <u>Assistant</u>                            |  |  |  | DATE SIGNED <u>12/22/79</u>   |  |  |  |   |  |
| EXAMINER'S NAME (TYPE OR PRINT) <u>Virginia L. Dolan, M.D.</u>  |         |   |  | ADDRESS <u>111 Penn St. Balto., MD.</u>                     |  |  |  |   |  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Removal</u>  |         |   |  | 23b. DATE <u>12-25-79</u>                                   |  | 23c. NAME OF CEMETERY OR CREMATORY <u>FORT LINCOLN</u>   |  |   |  | 23d. LOCATION (CITY OR TOWN) <u>Washington</u> COUNTY <u>DC.</u> STATE |  |   |  |
| 24. FUNERAL DIRECTOR NAME <u>Phillips Fun. Home Inc.</u> ADDRESS <u>1727 MONROE ST.</u>   |         |   |  | 25a. DATE REC'D. BY REGISTRAR <u>DEC 28 1979</u>            |  |  |  | 25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>                                 |  |  |  |   |  |

MEDICAL CERTIFICATION



*[Faint, mostly illegible handwritten text, possibly bleed-through from the reverse side of the page.]*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

19 30436

|  |   |  |        |  |   |                              |   |                           |                  |  |  |
|--|---|--|--------|--|---|------------------------------|---|---------------------------|------------------|--|--|
| 1 DECEASED NAME<br>(TYPE OR PRINT)   |   | FIRST  | MIDDLE | LAST   | 2a DATE OF DEATH  |                              | MONTH   | DAY                       | YEAR             | 2b HOUR                                      |  |
| ELEANOR K. MORELAND  |   |  |        |  | 12/30/79  |                              |   |                           |                  | 7:18 AM                                      |  |
| 3 SEX  | 4 RACE  | 5 DATE OF BIRTH  |        |  | 6 AGE (IN YEARS LAST BIRTHDAY)                                      |                              | 7a LIVING 1 YEAR  |                           | 7b LIVING 24 HRS |  |  |
| Female   | White   | MONTH 2 DAY 11 YEAR 25   |        |  | 54 YRS  |                              | MONTHS  |                           | DAYS             |  |  |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)   | 7b CITIZEN OF WHAT COUNTRY?   | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |        |  | 9 BALTIMORE CITY OR COUNTY OF DEATH                                 |                              |   |                           |                  |  |  |
| Wash., D.C.  | USA   |  |        |  | BALTIMORE CITY  |                              |   |                           | MD               |  |  |
| 10 CITY OR TOWN OF DEATH   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |        |  | 12a USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)     |                              | 12b KIND OF BUSINESS OR INDUSTRY                              |                           |                  |  |  |
| Balto.   | THE JOHNS HOPKINS HOSPITAL  |  |        |  | Homemaker   |                              |   |                           |                  |  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |   | 13a INSIDE CITY LIMITS?  |        | 13b STREET ADDRESS   |   |                              |   |                           |                  |  |  |
| 13a STATE  | 13b COUNTY  | 13c CITY OR TOWN   |        | YES <input type="checkbox"/> NO <input type="checkbox"/>   |   | 203 Yoakum Parkway           |   |                           |                  |  |  |
| Va.  |   | Alexandria   |        |  |   |                              |   |                           |                  |  |  |
| 14 FATHER'S NAME   |   | 15. MOTHER'S MAIDEN NAME   |        |  |   |                              |   |                           |                  |  |  |
| FIRST MIDDLE LAST  |   | FIRST MIDDLE LAST  |        |  |   |                              |   |                           |                  |  |  |
|  |   | Mary   |        |  |   |                              |   |                           |                  |  |  |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)  |   | 16b SOCIAL SECURITY NO.  |        | 17 INFORMANT   |   | ADDRESS                      |   |                           |                  |  |  |
| No   |   | 578-20-9281A   |        |  |   |                              |   |                           |                  |  |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1 DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>sepsis</u><br>DUE TO, OR AS A CONSEQUENCE OF (b)<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF (c)<br><u>0389</u>                       |   |  |        |  |   |                              |   |                           |                  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><u>Malnutrition</u>  |   |  |        |  |   |                              |   |                           |                  |  |  |
| 19a DATE OF OPERATION  |   | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED  |        |  | 20a AUTOPSY?  |                              | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |                           |                  |  |  |
|  |   |  |        |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                              | YES <input type="checkbox"/> NO <input type="checkbox"/>      |                           |                  |  |  |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |   | 21b TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |        | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |   |                              |   |                           |                  |  |  |
|  |   |  |        |  |   |                              |   |                           |                  |  |  |
| 21d INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |   | 21e PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |        | 21f LOCATION<br>STREET   |   | CITY OR TOWN                 |   | COUNTY                    |                  | STATE  |  |
|  |   |  |        |  |   |                              |   |                           |                  |  |  |
| 22a I certify that (I) (this hospital) attended the deceased from <u>12/27</u> 19 <u>79</u> to <u>12/30</u> 19 <u>79</u> , that (I) (we) last saw the deceased alive on <u>12/29/79</u> at <u>4pm</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |   |  |        |  |   |                              |   |                           |                  |  |  |
| 27b SIGNATURE  |   | DEGREE   |        | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |   | 27c DATE SIGNED              |   |                           |                  |  |  |
|  |   | MD   |        |  |   | 12/30                        |   |                           |                  |  |  |
| 27d PHYSICIAN'S NAME (TYPE OR PRINT)   |   | 27e ADDRESS  |        |  |   |                              |   |                           |                  |  |  |
| AMBRIDGER  |   | Johns Hopkins  |        |  |   |                              |   |                           |                  |  |  |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY)   |   | 23b DATE   |        | 23c NAME OF CEMETERY OR CREMATORY  |   | 23d LOCATION<br>CITY OR TOWN |   | COUNTY                    |                  | STATE  |  |
| Removal  |   | 12/30/79   |        |  |   |                              |   |                           |                  |  |  |
| 24 FUNERAL DIRECTOR<br>NAME  |   |  |        | ADDRESS  |   | 25a DATE REC'D. BY REGISTRAR |   | 25b REGISTRAR'S SIGNATURE |                  |  |  |
| Anatomy Board  |   |  |        | Balto., Md.  |   | JAN 3 1980                   |   | P. J. McCreedy            |                  |  |  |

BP

SECRET

THE SECRETARY OF THE ARMY

WASHINGTON, D. C.

DEPARTMENT OF THE ARMY

OFFICE OF THE SECRETARY

WASHINGTON, D. C.

THE SECRETARY OF THE ARMY

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other funeral service.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  |  |   |   |  |  |  |
|---|--|--|--|--|---|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FANE WILLIAM MORETZ  |  |  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>12 10 79               |   |  | 2b. HOUR<br>9:45 P.M.  |  |
| 3 SEX<br>Male   |  | 4 RACE<br>White  |  | 5 DATE OF BIRTH<br>MONTH DAY YEAR<br>10-5-19   |   | 6 AGE (IN YEARS LAST BIRTHDAY)<br>60 YRS  |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN  |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br>N.C.  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9 BALTIMORE CITY OR COUNTY OF DEATH<br>Balto. City MD.  |  |  |  |
| 10 CITY OR TOWN OF DEATH<br>Balto.  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Church Hospital |  |  |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Superintendent              |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Construction  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |  |  |  |   |   |  |  |  |
| 13a. STATE<br>Md.   |  | 13b. COUNTY<br>Balto   |  | 13c. CITY OR TOWN<br>Balto   |   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS<br>5415 Forge Rd.  |  |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br>Charles L. Moretz  |  |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Gladys Styke |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>Yes   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>WWII  |  | 17 INFORMANT ADDRESS<br>Glenna D. Moretz, 5415 Forge Rd.   |   |   |  |  |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) INTRACTABLE VENTRICULAR FIBRILLATION<br>410-<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) ACUTE INFERIOR MYOCARDIAL INFARCTION<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |  |  |  |   |   |  |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |  |  |  |   |   |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  |   | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |   |   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |   |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 12-8 19 79, to 12-10 19 79, that (I) (we) last saw the deceased alive on 12-10 19 79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                                 |  |  |  |  |   |   |  |  |  |
| 22b. SIGNATURE<br>W. Impagliatelli  |  | DEGREE   |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                            |   |   |  | 22c. DATED AND SIGNED<br>12/10/79  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>WALKER IMPAGLIATELLI, M.D.   |  |  |  | 22e. ADDRESS<br>CHURCH HOSPITAL CORPORATION 21231<br>100 NORTH BROADWAY, BALTIMORE, MARYLAND   |   |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial  |  | 23b. DATE<br>12-13-79  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Holly Hill   |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>White Marsh Balto. Md.                            |  |  |  |
| 24 FUNERAL DIRECTOR<br>NAME<br>Leonard J. Ruck, Inc., 5305 Harford Rd.  |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br>DEC 12 1979   |   | 25b. REGISTRAR'S SIGNATURE<br>[Signature]   |  |  |  |

BP.



DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH7 9 3 0 4 3 8  
REG. NO.1- FOR  
STATE  
REGISTRAR

George William Morgan

|  |  |   |   |  |                                      |   |  |  |  |  |  |
|--|--|---|---|--|--------------------------------------|---|--|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>MORGAN GEORGE</b>   |  |   | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>12-18-79</b> |  | 2b. HOUR<br><b>7<sup>25</sup> PM</b> |   |  |  |  |  |  |
| 3 SEX<br><b>Male</b>   |  | 4 RACE<br><b>White</b>  |   | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>8/27/1907</b>  |                                      | 6 AGE (IN YEARS LAST BIRTHDAY)<br><b>73</b> YRS   |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN   |  | IF UNDER 24 HRS<br>HOURS MIN   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |   | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                      | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.                        |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Baltimore City Hospital</b> |   |  |                                      | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Metalurgical</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Beth. Steel</b>  |  |  |  |
| 13a. STATE<br><b>Maryland</b>  |  |   |   | 13b. COUNTY<br><b>Baltimore</b>  |                                      | 13c. CITY OR TOWN<br><b>Dundalk</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 13e. STREET ADDRESS<br><b>103 Kinship Road 21222</b>   |  |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Charles H. Morgan</b>  |  |   |   | 15 MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Florence Ault</b>   |                                      |   |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>  |  |   |   | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>213-09-1374</b>  |                                      | 17 INFORMANT<br><b>Marian E. Morgan</b>   |  | ADDRESS<br><b>103 Kinship Road Balto., Md. 21222</b>   |  |  |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CARDIAC ARREST</b><br><b>4275</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) <b>bad heart</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>bad heart</b><br>DUE TO, OR AS A CONSEQUENCE OF |  |   |   |  |                                      |   |  |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):   |  |   |   |  |                                      |   |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  |   |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |                                      |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |                                      | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)          |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |   |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |                                      | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                       |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>12-18</b> , 19 <b>79</b> , to <b>12-18</b> , 19 <b>79</b> , that (I) (we) lost<br>saw the deceased alive on <b>12-18</b> , 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.                |  |   |   |  |                                      |   |  |  |  |  |  |
| 22b. SIGNATURE<br><b>W. Marley</b>   |  |   |   | DEGREE<br><b>MD</b>  |                                      |   |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br><b>12-18-79</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Marley</b>   |  |   |   | 22e. ADDRESS<br><b>Belt - City Hospital</b>  |                                      |   |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |  |   |   | 23b. DATE<br><b>12/22/79</b>   |                                      | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Oak Lawn Cemetery</b>                          |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore, Maryland</b>   |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Duda-Ruck, Inc., Baltimore, Md. 21222</b>   |  |   |   | ADDRESS<br><b>FC 21 1979</b>   |                                      | 25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE<br><b>12-18-79</b>             |  |  |  |  |  |

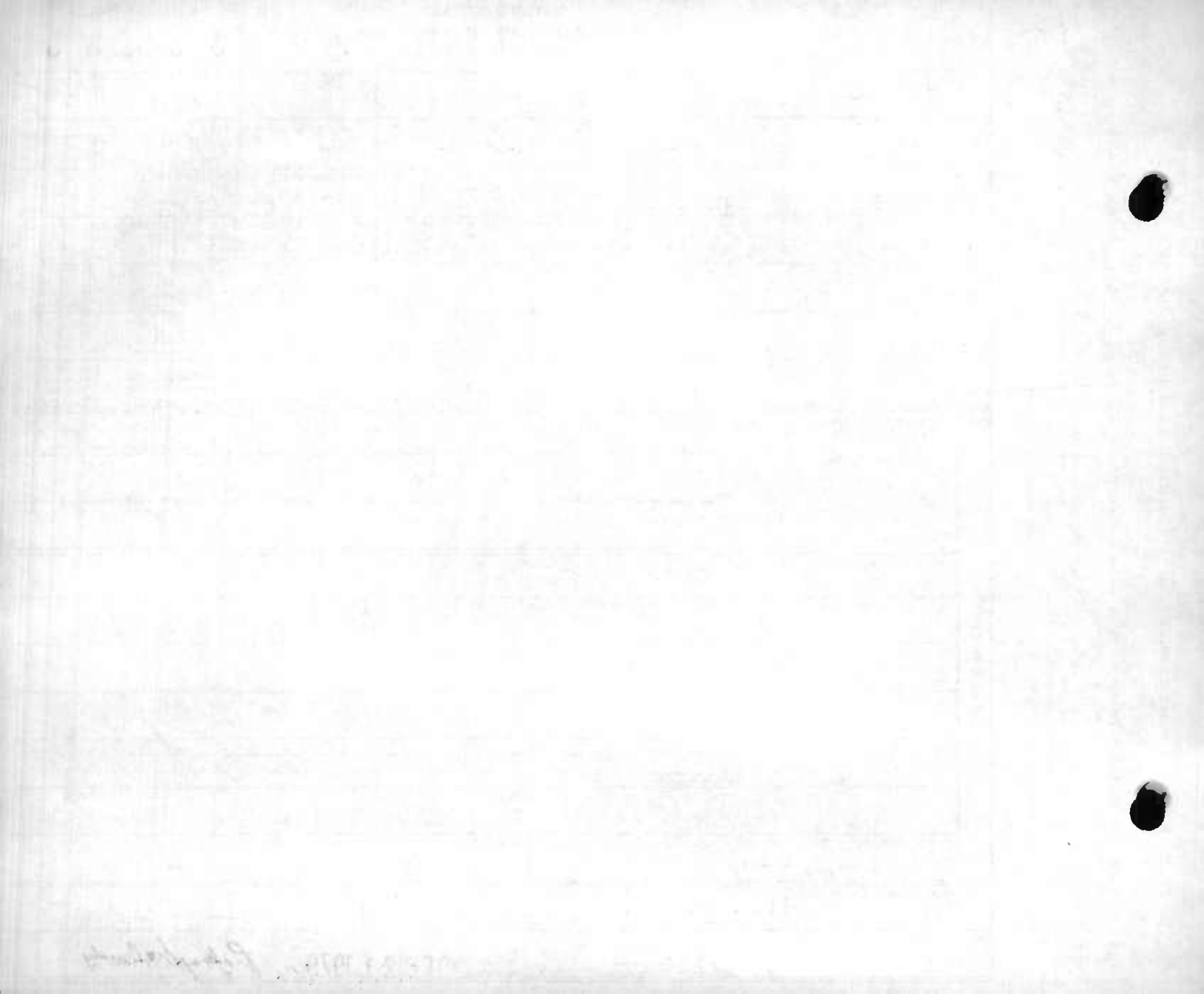
MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

BP

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



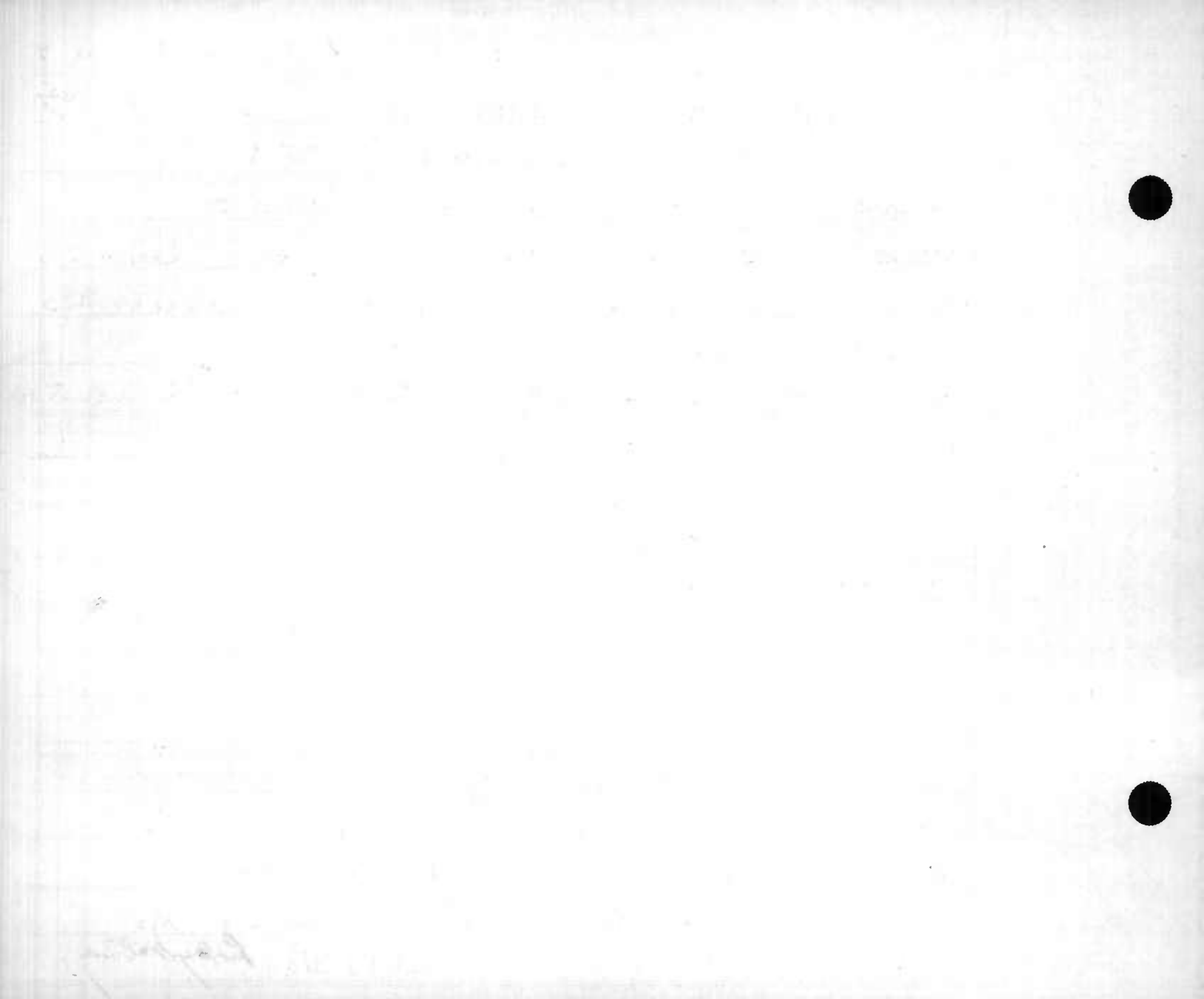


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  |  |  |  |  |   |  |  |  |
|--|--|--|--|--|--|--|--|---|--|--|--|
| 1. FOR STATE REGISTRAR   |  | 7 9 3 0 4 3 9<br>REG. NO.  |  |  |  |  |  |   |  |  |  |
| 1. DECEASED NAME (TYPE OR PRINT)   |  | FIRST  |  | MIDDLE   |  | LAST   |  | 2a. DATE OF DEATH MONTH DAY YEAR  |  | 2b. HOUR                                     |  |
| MARY   |  | H.   |  | MORGAN   |  |  |  | 12 9 79   |  | 10 45 P.M.                                   |  |
| 3. SEX   |  | 4. RACE  |  | 5. DATE OF BIRTH MONTH DAY YEAR  |  | 6. AGE (IN YEARS LAST BIRTHDAY)  |  | 7. IF UNDER 1 YEAR MONTHS DAYS  |  | 8. IF UNDER 24 HRS. HOURS MIN.               |  |
| F  |  | W  |  | 12 - 23 - 1903   |  | 75 YRS.  |  |   |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH   |  |   |  |  |  |
| MARYLAND   |  | U. S. A.   |  |  |  | BALTIMORE CITY MD.   |  |   |  |  |  |
| 10. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                                |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |  |  |
| BALTIMORE  |  | UNION MEMORIAL HOSPITAL  |  |  |  | DIPPER   |  | CANDY IND.  |  |  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  |  |  |  |  |  |  |   |  |  |  |
| 13a. STATE   |  | 13b. COUNTY  |  | 13c. CITY OR TOWN  |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS   |  |  |  |
| MD.  |  |  |  | BALTO.   |  |  |  | 4837 GREENCREST RD  |  |  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST  |  |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST   |  |  |  |   |  |  |  |
| JAMES MIXON  |  |  |  | BARBARA -  |  |  |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)  |  |  |  | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT ADDRESS  |  |   |  |  |  |
| No   |  |  |  | 218-22-8606  |  | Mr. William I. Scott - 4837 Greencrest Rd.   |  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:  |  |  |  |  |  |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| IMMEDIATE CAUSE (a) <u>Cardiopulmonary arrest</u>  |  |  |  |  |  |  |  |   |  |  |  |
| 5849 DUE TO, OR AS A CONSEQUENCE OF  |  |  |  |  |  |  |  |   |  |  |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last  |  |  |  |  |  |  |  |   |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF (b) <u>Acute renal failure, septic shock</u>  |  |  |  |  |  |  |  |   |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF (c) <u>Septic shock</u>   |  |  |  |  |  |  |  |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Atherosclerotic vascular disease</u>  |  |  |  |  |  |  |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)   |  |  |  |   |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |  |  |   |  |  |  |
| 22. I certify that (this hospital) attended the deceased from <u>12/13/79</u> to <u>12/19/79</u> , that (we) last saw the deceased alive on <u>12/19/79</u> , and that in (our) opinion death occurred on the date and hour and from the causes stated above. (I) <input checked="" type="checkbox"/> (we) (did) <input type="checkbox"/> not view the body after death. |  |  |  |  |  |  |  |   |  |  |  |
| 22b. SIGNATURE <u>Joseph D'Antonio A. MD.</u> DEGREE   |  |  |  |  |  | 22c. DATE SIGNED <u>12/19/79</u>   |  |   |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>JOSEPH D'ANTONIO MD</u>   |  |  |  |  |  | 22e. ADDRESS <u>UNION MEMORIAL HOSPITAL</u>  |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION CITY COUNTY STATE  |  |   |  |  |  |
| BURIAL   |  | 12-13-79   |  | MORELAND MEMORIAL  |  | BALTO. MD.   |  |   |  |  |  |
| 24. FUNERAL DIRECTOR NAME <u>Harley Miller</u> ADDRESS <u>7527 Harford Rd.</u>   |  |  |  |  |  | 25a. DATE REC'D. BY REGISTRAR  |  | 25b. REGISTRAR'S SIGNATURE <u>Harley Miller</u>   |  |  |  |
|  |  |  |  |  |  | DEC 13 1979  |  |   |  |  |  |





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

179-42-35-300-1

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  |   |  |  |  |  |  | 79 30440<br>REG. NO.  |  |  |  |
|--|--|--|--|---|--|--|--|--|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) FIRST MIDDLE LAST<br><b>ERISKA MORGENROTH</b>  |  |  |  |   |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>12 13 79</b>  |  |  |  | 2b. HOUR<br><b>10:50 PM</b>   |  |  |  |
| 3. SEX<br><b>FEMALE</b>  |  | 4. RACE<br><b>WHITE</b>  |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>11 7 1893</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>86</b> YRS.  |  | IF UNDER 1 YEAR MONTHS DAYS  |  | IF UNDER 24 HRS. HOURS MIN.   |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>GERMANY</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>       |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.                              |  |  |  |   |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE CITY</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>SINAI HOSPITAL OF BALTO.</b> |  |   |  |  |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>HOUSEWIFE</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>AT HOME</b>   |  |  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  |  |  |   |  | 13a. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  |  |  |   |  |  |  |
| 13a. STATE<br><b>MARYLAND</b>  |  | 13b. COUNTY<br><b>-</b>  |  | 13c. CITY OR TOWN<br><b>BALTIMORE</b>   |  | 13e. STREET ADDRESS APT. B-4<br><b>6007 PARK HTS. AVE. 21215</b>                               |  |  |  |   |  |  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>VICTOR - COHEN</b>   |  |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE<br><b>AUGUSTA HESS</b>  |  |  |  |  |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br><b>NO</b>   |  |  |  | 16b. SOCIAL SECURITY NO.<br><b>-</b>  |  | 17. INFORMANT ADDRESS<br><b>HANS MORGENROTH</b><br><b>6007 PARK HTS. AVE., APT. B-4 #21215</b> |  |  |  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CARCINOMA OF UTERUS</b><br>179-<br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>MYOCARDIAL INSUFFICIENCY</b> 10 days.<br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>-</b>   |  |  |  |   |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)<br><b>HYPERTENSION</b>   |  |  |  |   |  |  |  |  |  |   |  |  |  |
| 19a. DATE OF OPERATION<br><b>-</b>   |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>-</b>  |  |  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>    |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><b>P.M. - 19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)<br><b>-</b>     |  |  |  |   |  |  |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/><br><b>-</b>   |  |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)<br><b>-</b>   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE<br><b>- - - - -</b>                             |  |  |  |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>12-4-</b> 19 <b>79</b> , to <b>12-13-</b> 19 <b>79</b> , that (I) (we) last saw the deceased alive on <b>12-13</b> 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |   |  |  |  |  |  |   |  |  |  |
| 22b. SIGNATURE<br><b>Asnani.</b>   |  |  |  | DEGREE<br><b>MD</b><br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  |  |  | 22c. DATE SIGNED<br><b>12-13-79</b>  |  |   |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>HARESH ASNANI</b>  |  |  |  |   |  | 22e. ADDRESS<br><b>SINAI HOSPITAL OF BALTIMORE</b>   |  |  |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>BURIAL</b>   |  | 23b. DATE<br><b>DEC. 14, 1979</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>CHEVRA AHAVAS CHESSED</b>  |  |  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><b>RANDALLSTOWN BALTO. MD</b>             |  |   |  |  |  |
| 24. FUNERAL DIRECTOR NAME<br><b>SOL LEVINSON &amp; BROS., INC.</b><br><b>6010 REISTERSTOWN RD. BALTO., MD 21215</b>  |  |  |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>DEC 20 1979</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><i>Richard A. Brady</i>                                |  |   |  |  |  |



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STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

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REG. NO.

1- FOR  
STATE  
REGISTRAR

|   |   |  |  |  |   |   |
|---|---|--|--|--|---|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Anthony Andrew Morgol</b>  |   |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>12-2-79</b>   |  | 2b. HOUR<br><b>6:15P</b>  |   |
| 3 SEX<br><b>MALE</b>  | 4 RACE<br><b>WHITE</b>  | 5. DATE OF BIRTH<br><b>12-15-87</b> YEAR   |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br><b>91</b> YRS                                      |   | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN  |
| 7a BIRTHPLACE (STATE OR FOREIGN)<br><b>RUSSIA</b>   | 7b CITIZEN OF WHAT COUNTRY?<br><b>Russia</b>  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.                     |   |   |
| 10 CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br><b>LUTHERAN HOSPITAL</b> |  | 12a USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Furniture Finisher</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY   |   |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13b. STATE<br><b>Maryland</b>   |   |  | 13c. CITY OR TOWN<br><b>Baltimore</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>unknown</b>   |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>unknown</b>                              |  |   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>   |   | 16b. SOCIAL SECURITY NO.<br><b>216-07-1101</b>   |  | 17 INFORMANT ADDRESS<br><b>Mary, Liberto 7313 Campfield Rd. 21208</b>                |   |   |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1: DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <b>Pneumonia</b><br><b>5070</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>ASPIRATION</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>4 days</b>                |   |  |  |  |   |   |
| PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (b)   |   |  |  |  |   |   |
| 19a. DATE OF OPERATION  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>           |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)       |   |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |   |   |
| 22a. I certify that (1) this hospital attended the deceased from <b>12/2</b> 19 <b>79</b> , to <b>12/2</b> 19 <b>79</b> , that (2) I have just saw the deceased alive on <b>12/2/79</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (If we did not view the body after death, so state.) |   |  |  |  |   |   |
| 22b. SIGNATURE<br><b>Richard Diamond</b>  |   | DEGREE   |  | 22c. DATE SIGNED<br><b>12/2/79</b>   |   | 22d. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |
| 22e. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>DIAMOND, RICHARD</b>  |   | 22f. ADDRESS<br><b>Lutheran Hosp</b>   |  |  |   |   |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>BURIAL</b>  |   | 23b. DATE<br><b>12/5/1979</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Holy Trinity RUSSIAN</b>                    |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>ELKridge - Howard Co MD.</b>   |
| 24 FUNERAL DIRECTOR<br><b>Loring Byers Funeral Directors</b><br><b>8728 Liberty Road Randallstown, Md. 21133</b>  |   |  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>DEC 4 1979</b>                                   |   | 25b. REGISTRAR'S SIGNATURE<br><b>Loring Byers</b>   |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal, and in any event, within 72 hours after death.



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# STATE OF MARYLAND

## DEPARTMENT OF HEALTH AND MENTAL HYGIENE

### CERTIFICATE OF DEATH

30442

|   |                         |   |   |   |  |
|---|-------------------------|---|---|---|--|
| 1. DECEASED-NAME<br>(Type or print) <u>Melissa Ann Morris</u>   |                         |   | 2a. DATE OF DEATH<br>12 Month 5 Day 79 Year |   | 2b. HOUR<br>12:29 AM   |
| 3. SEX<br><u>Female</u>   | 4. RACE<br><u>White</u> | 5. DATE OF BIRTH<br><u>11/29/79</u>   |   | 6. AGE (In years<br>last birthday)<br><u>0</u> YRS.   | IF UNDER 1 YEAR<br>MONTHS <u>6</u> DAYS  |
| 7a. BIRTHPLACE (State or foreign<br>country) <u>Md</u>  |                         | 7b. CITIZEN OF WHAT COUNTRY?<br><u>USA</u>  |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |
| 9. COUNTY OF DEATH<br><u>Baltimore City</u> Md.   |                         |   |   |   |  |
| 10. CITY OR TOWN OF DEATH<br><u>Baltimore</u>   |                         | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital<br>give street address)<br><u>Univ. of Md</u> |   | 12a. USUAL OCCUPATION (Kind of work done<br>during most of working life, even if retired.)<br><u>none</u>   |  |
| 12b. KIND OF BUSINESS OR<br>INDUSTRY<br><u>none</u>   |                         |   |   |   |  |
| 13a. USUAL RESIDENCE (Where deceased lived; if institution: Residence before<br>admission) STATE <u>Md</u>  |                         | 13b. COUNTY<br><u>Queen Anne</u>  | 13c. CITY OR TOWN<br><u>Church Hill</u>     | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   | 13e. STREET AND NUMBER<br><u>158 Church Hill, Md</u>                             |
| 14. FATHER'S NAME First <u>William</u> Middle <u>Morris Jr.</u> Last <u>Deborah Jean Morris</u>   |                         | 15. MOTHER'S MAIDEN NAME First <u>Deborah</u> Middle <u>Jean</u> Last <u>Morris</u>                   |   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) <u>no</u>   |                         | 16b. SOCIAL SECURITY NO.<br><u>none</u>   |   | 17. INFORMANT<br><u>William Edwin Morris</u> Address <u>Box 158</u><br><u>Church Hill Md. 21623</u>   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cardiac arrest</u><br><u>7762</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave<br>rise to immediate cause (a),<br>stating the underlying cause<br>lost. (b) <u>acidosis</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>sepsis or metabolic inborn error</u>  |                         |   |   |   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br><u>40 min</u><br><u>24 hr</u> |
|   |                         |   |   |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><u>Pt Had Developed DIC, Respiratory distress &amp; poor cardiac output</u>  |                         |   |   |   |  |
| 19a. DATE OF OPERATION<br><u>N/A</u>  |                         | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><u>N/A</u>  |   | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  |
| 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING<br>CAUSES OF DEATH?<br><u>no</u>  |                         |   |   |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  |                         | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <u>19</u>                                     |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work  |                         | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,<br>OFFICE BUILDING, ETC.)                       |   | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>4 Dec</u> , 19 <u>79</u> , to <u>5 Dec</u> , 19 <u>79</u> , that (I) <del>(we)</del> last<br>saw the deceased alive on <u>5 Dec</u> , 19 <u>79</u> , and that in (my) <del>(our)</del> opinion death occurred on the date and hour and from the<br>causes stated above, (I) <del>(we)</del> (did) <del>(did not)</del> view the body after death. |                         |   |   |   |  |
| 22b. SIGNATURE<br><u>DB Call MD</u>   |                         |   |   | 22c. DATE SIGNED<br><u>12/5/79</u>  |  |
| 22d. PHYSICIAN'S<br>NAME (Type) <u>D B Call MD</u>  |                         |   |   | 22e. ADDRESS<br><u>22 S. Green St, Baltimore, Md</u>  |  |
| 23a. BURIAL, CREMATION,<br>REMOVAL (Specify)<br><u>Burial</u>   |                         | 23b. DATE<br><u>12-8-79</u>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Church Hill Cemetery</u>   |  |
| 23d. LOCATION (City or Town)<br><u>Church Hill</u>  |                         | (County)<br><u>Q. A. Md.</u>  |   | (State)<br><u>Md.</u>   |  |
| 24. FUNERAL DIRECTOR<br><u>Helfenbein-Hubbard F.H.</u>  |                         |   |   | 25a. REC'D BY REGISTRAR<br><u>DEC 17 1979</u>   |  |
| ADDRESS<br><u>Church Hill Md.</u>   |                         |   |   | 25b. REGISTRAR'S SIGNATURE<br><u>Henry McHenry</u>  |  |







TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

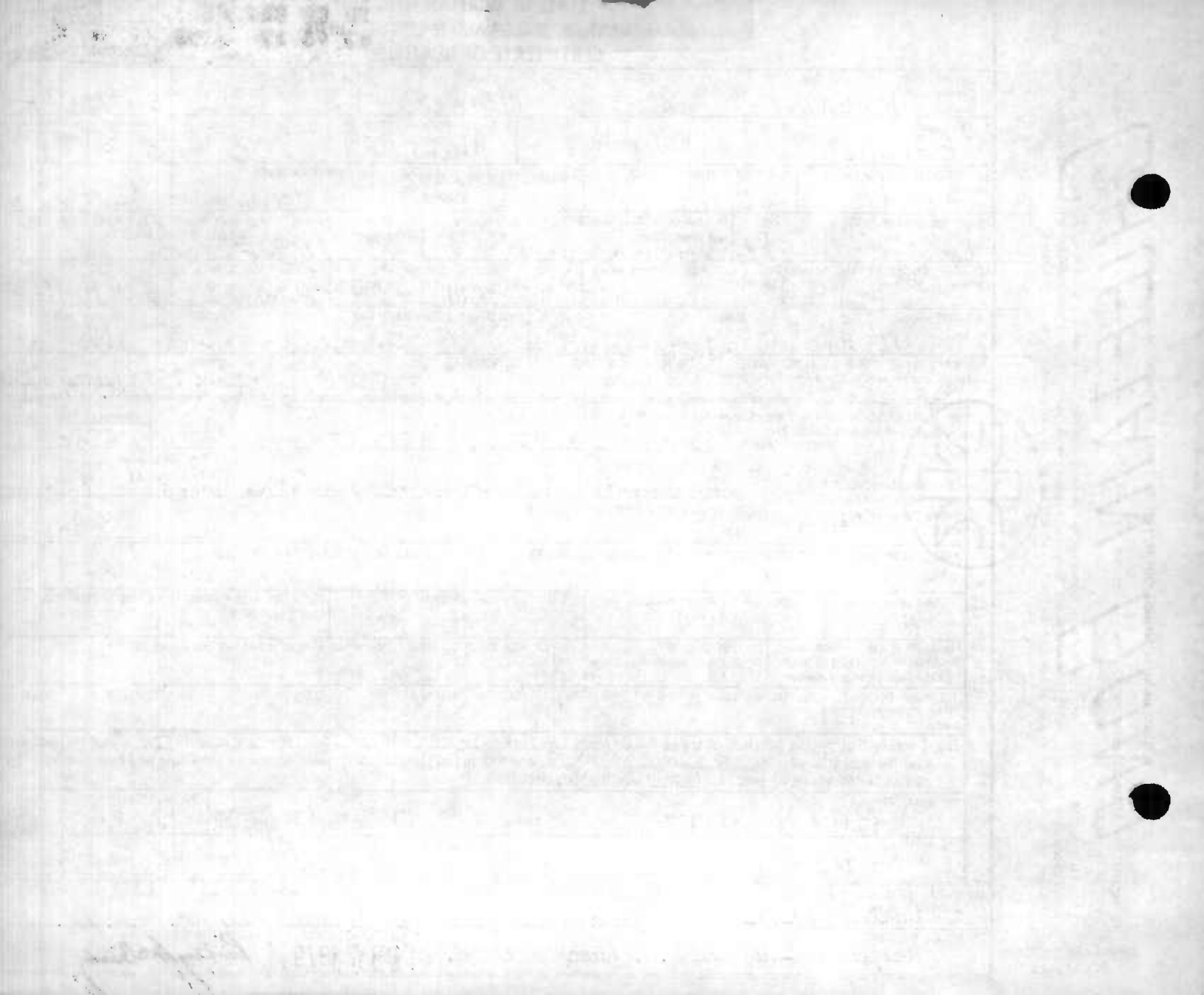
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal, and in any event, within 72 hours after death.

## STATE OF MARYLAND

## DEPARTMENT OF HEALTH AND MENTAL HYGIENE

## CERTIFICATE OF DEATH

|  |  |  |  |   |  |  |  |
|--|--|--|--|---|--|--|--|
| 1. DECEASED-NAME<br>(Type or print) <b>MELANIE SUE MORRIS</b>  |  |  | 20. DATE OF DEATH<br>Month <b>12</b> Day <b>8</b> Year <b>79</b> |   |  | 2b. HOUR<br><b>9:40 A M</b>  |  |
| 3. SEX<br><b>Female</b>  |  | 4. RACE<br><b>White</b>  |  | 5. DATE OF BIRTH<br><b>11/29/79</b>   |  | 6. AGE (In years last birthday)<br><b>0</b> YRS. <b>0</b> MONTHS <b>8</b> DAYS   |  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>Md</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br><b>Baltimore City Md.</b>  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore City</b>   |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>Vol Md Hosp</b> |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>NONE</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><b>Md</b>   |  | 13b. COUNTY<br><b>Queen Anne's Church Hill</b>   |  | 13c. CITY OR TOWN<br><b>YES</b> <input type="checkbox"/> <b>NO</b> <input checked="" type="checkbox"/>  |  | 13d. INSIDE CITY LIMITS?<br><b>YES</b> <input type="checkbox"/> <b>NO</b> <input checked="" type="checkbox"/>                                  |  |
| 14. FATHER'S NAME<br>First <b>William Edwin</b> Middle <b>Morris</b> Last <b>Jr</b>  |  | 15. MOTHER'S MAIDEN NAME<br>First <b>Deborah</b> Middle <b>Jean</b> Last <b>Morris</b>             |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)<br><b>No</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>N/A</b>   |  |
| 17. INFORMANT<br><b>Hospital Record</b>  |  | 18. ADDRESS<br><b>Box 158 Church Hill Md. 21623</b>  |  | 19. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>6 hr</b>   |  | 20. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>8 hr</b>  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br><b>0389</b><br>IMMEDIATE CAUSE (a) <b>Cardio pulmonary arrest</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Disseminated Intravascular Coagulation</b> with possible Intracranial bleed<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Sepsis</b><br>3 days   |  |  |  |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><b>Acidosis</b>  |  |  |  |   |  |  |  |
| 19a. DATE OF OPERATION<br><b>N/A</b>   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>N/A</b>                                     |  | 20a. AUTOPSY?<br><b>YES</b> <input type="checkbox"/> <b>NO</b> <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?<br><b>no</b>  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)<br><b>White</b> <input type="checkbox"/> <b>Not white</b> <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>   |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <b>19</b>                                  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)   |  |  |  |
| 21d. INJURY OCCURRED<br><b>White</b> <input type="checkbox"/> <b>Not white</b> <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                       |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |  |  |
| 22a. I certify that <del>(the)</del> (this hospital) attended the deceased from <b>4 Dec</b> , 19 <b>79</b> , to <b>8 Dec</b> , 19 <b>79</b> , that (I) <del>(we)</del> last saw the deceased alive on <b>8 Dec</b> , 19 <b>79</b> , and that in (my) <del>(our)</del> opinion death occurred on the date and hour and from the causes stated above, (I) <del>(we)</del> (did) <del>(did not)</del> view the body after death. |  |  |  |   |  |  |  |
| 22b. SIGNATURE<br><b>DBCall MD</b>   |  |  |  | 22c. DATE SIGNED<br><b>12/8/79</b>  |  | 22d. DEGREE<br>ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> |  |
| 22e. PHYSICIAN'S NAME (Type)<br><b>DBCall MD</b>   |  |  |  | 22f. ADDRESS<br><b>22 S Green St., Balt, Md</b>   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |  | 23b. DATE<br><b>12-11-79</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Church Hill Cemetery</b>   |  | 23d. LOCATION (City or Town) (County) (State)<br><b>Church Hill Md. Q.A. Md.</b>   |  |
| 24. FUNERAL DIRECTOR<br><b>Helfenbein-Hubbard F.H.</b>   |  |  |  | 25a. REC'D BY REGISTRAR<br><b>DEC 17 1979</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>Robert McBratney</b>  |  |

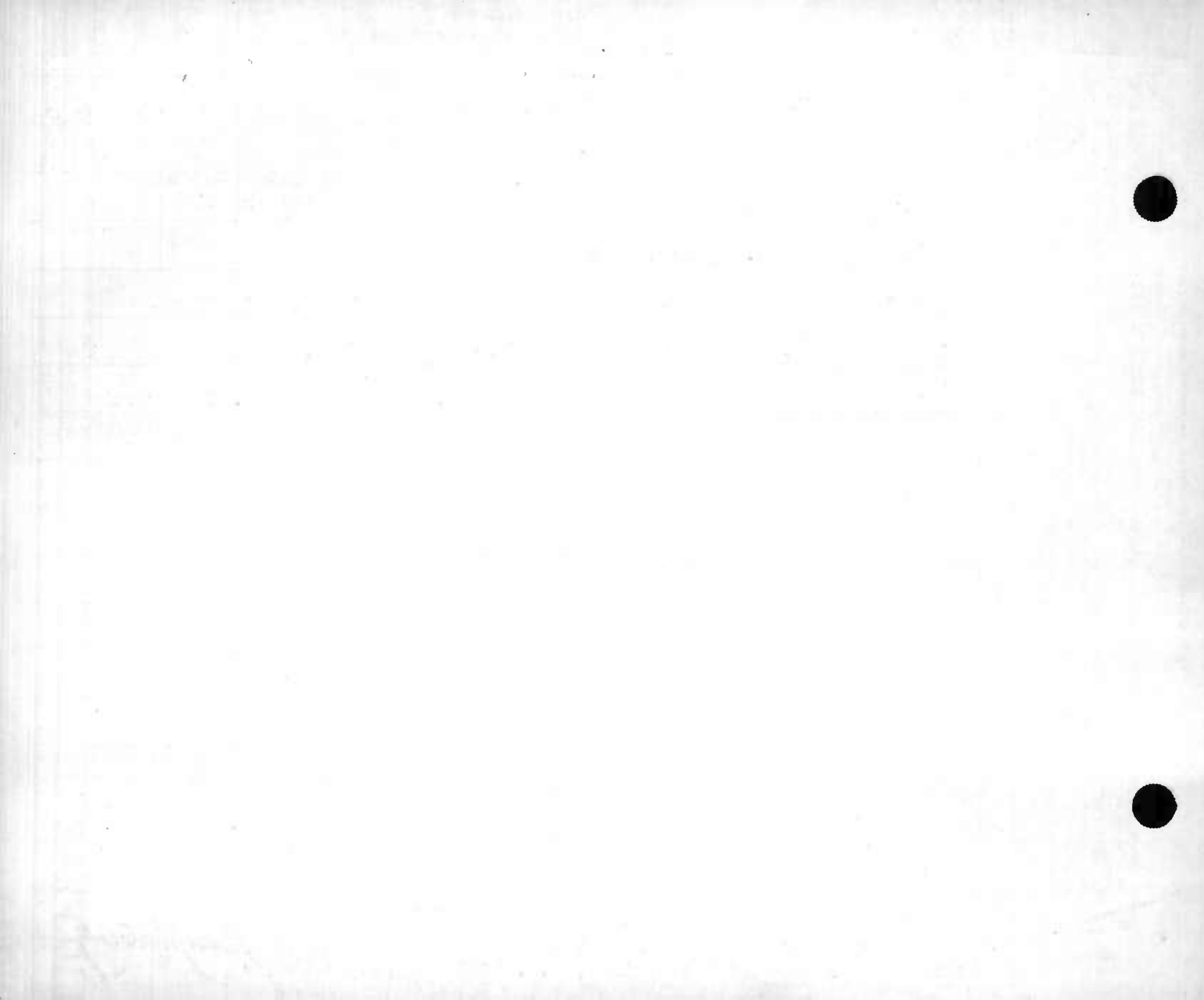


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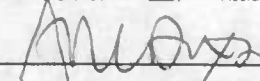
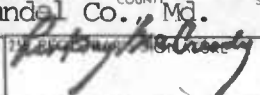
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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |   |  |  |  |  |  |  |   |  |
|---|--|---|--|--|--|--|--|--|---|--|
| 1. FOR<br>STATE<br>REGISTRAR  |  | 7 9 3 0 4 4 4   |  |  |  | REG. NO.   |  |  |   |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>EVELYN RUTH MORRISON.  |  |   |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>11-7-79   |  |  | 2b. HOUR<br>6 p.m.   |   |  |
| 3 SEX<br>Female   |  | 4 RACE<br>White   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>11/7//79   |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br>YRS MONTHS DAYS<br>3 30                |  | 7. IF UNDER 1 YEAR<br>IF UNDER 24 HRS<br>HOURS MIN<br>3 30 |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U S A   |  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.               |  |  |   |  |
| 10 CITY OR TOWN OF DEATH<br>Baltimore   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>St. Agnes Hospital |  |  |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>none |  | 12b. KIND OF BUSINESS OR INDUSTRY                          |   |  |
| 13a. STATE<br>Maryland  |  |   |  |  | 13b. COUNTY<br>Balto   |  | 13c. CITY OR TOWN<br>Arbutus   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br>David C. Morrison  |  |   |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Susan L. Skiratko   |  |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>none   |  | 17 INFORMANT ADDRESS<br>David C. Morrison, 111 S. Twin Circle 21227  |  |  |  |  |   |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>CARDIO-RESPIRATORY ARREST</u><br><u>7650</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>NON-VIABILITY</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>PREMATURITY</u> |  |   |  |  |  |  |  |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |   |  |  |  |  |  |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |  |  |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |  |  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>11-7-79</u> to <u>11-7-79</u> , that (I) (we) last saw the deceased alive on <u>11-7-79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |   |  |  |  |  |  |  |   |  |
| 22b. SIGNATURE<br><u>Patricia L. Saldana</u>  |  |   |  |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  |  | 22c. DATE SIGNED<br>11-7-79                                |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>PATRICIA L. SALDANA  |  |   |  |  | 22e. ADDRESS<br>ST. AGNES HOSP.  |  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial   |  | 23b. DATE<br>1/16/80  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>New Cathedral  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore Maryland         |  |  |   |  |
| 24 FUNERAL DIRECTOR NAME<br>1630 Edmondson Ave., Catonsville, Md.<br>Witzke Funeral Home of Catonsville, P.A. 21228   |  |   |  |  |  |  |  |  |   |  |
| 25a. DATE REC'D. BY REGISTRAR<br>JAN 21 1980  |  |   |  |  | 25b. SIGNATURE   |  |  |  |   |  |



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PA 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED. WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |                         |  |   |  |   |   |   |  |  | REG. NO. 7 30445 |  |
|--|-------------------------|--|---|--|---|---|---|--|--|------------------|--|
| 1- STATE REGISTRAR   |                         | 1. DECEASED NAME<br>(TYPE OR PRINT) <b>JOHN MOSLEY</b>   |   |  |   | 2a. DATE KNOWN OF DEATH<br>ESTIMATED <input type="checkbox"/> <b>12 10 19 79</b>                        |   | 2b. HOUR <b>M</b>                                |  |                  |  |
| 3. SEX<br><b>male</b>  | 4. RACE<br><b>negro</b> | 5. DATE OF BIRTH<br>MONTH <b>2</b> DAY <b>16</b> YEAR <b>50</b>  | 6. AGE (IN YEARS)<br>(LAST BIRTHDAY) <b>29</b> YRS. | IF UNDER 1 YR.<br>MONTHS <b>0</b> DAYS <b>0</b>  | IF UNDER 24 HRS.<br>HOURS <b>0</b> MIN <b>0</b>               | 2c. DATE PRONOUNCED DEAD<br>MONTH <b>12</b> DAY <b>10</b> YEAR <b>19 79</b>                             |   | 2d. HOUR <b>1:30</b> <b>M</b>                    |  |                  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>N.C</b>  |                         | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.                                       |   |  |  |                  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |                         | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Union Memorial Hospital</b> |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) |   | 12b. KIND OF BUSINESS OR INDUSTRY   |  |  |                  |  |
| 13a. STATE <b>Md.</b>  |                         | 13b. COUNTY  |   | 13c. CITY OR TOWN<br><b>Balto.</b>   |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>         |   | 13e. STREET ADDRESS<br><b>324 E. 22nd Street</b> |  |                  |  |
| 14. FATHER'S NAME<br>FIRST <b>Samie</b> MIDDLE <b>Mosley</b> LAST <b>Mosley</b>  |                         |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>Della</b> MIDDLE <b>Mae</b> LAST <b>Harris</b>  |   |   |   |  |  |                  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br><b>No</b>   |                         | 16b. SOCIAL SECURITY NO.<br><b>217-50-6741</b>   |   | 17. INFORMANT<br><b>Della M. Harris</b>  |   | ADDRESS<br><b>1300 E. Lanvale St.</b>   |   |  |  |                  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Stab wound of chest</b><br><b>966-</b><br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>DUE TO, OR AS A CONSEQUENCE OF   |                         |  |   |  |   |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH     |  |                  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).  |                         |  |   |  |   |   |   |  |  |                  |  |
| 19a. DATE OF OPERATION   |                         | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |   |  |   |   | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  |                  |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |                         | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>12:40xx 12-10-19 79</b>  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)<br><b>Stabbed during argument.</b>                                 |   |   |   |  |  |                  |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>  |                         | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)<br><b>house</b>  |   | 21f. LOCATION<br>STREET <b>324 E. 22nd St., Balto.</b> CITY OR TOWN <b>Balto.</b> COUNTY <b>Md.</b> STATE <b>Md.</b>                             |   |   |   |  |  |                  |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input checked="" type="checkbox"/> , Undetermined manner <input type="checkbox"/> . |                         |  |   |  |   |   |   |  |  |                  |  |
| ACTUAL SIGNATURE<br>  |                         | TITLE (SPECIFY)<br><b>Assistant</b> M.D.   |   | MEDICAL EXAMINER   |   | DATE SIGNED <b>12-10-79</b>   |   |  |  |                  |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT) <b>Ann M. Dixon, M.D.</b>   |                         | ADDRESS <b>111 Penn St.</b>  |   |  |   |   |   |  |  |                  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY) <b>Burial</b>   |                         | 23b. DATE<br><b>12/14/79</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Mt. Calvary Cem.</b>  |   | 23d. LOCATION<br>CITY OR TOWN <b>Anne Arundel Co.</b> COUNTY <b>Md.</b> STATE <b>Md.</b>                |   |  |  |                  |  |
| 24. FUNERAL DIRECTOR<br>NAME <b>Wm C March F/H</b>   |                         | ADDRESS <b>1101 E. North Ave.</b>  |   | 25a. DATE REC'D. BY REGISTRAR<br><b>DEC 13 1979</b>  |   | 25b. SIGNATURE<br> |   |  |  |                  |  |

NOV 10 1910



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  | REG. NO. 7930446  |  |  |  |
|---|--|---|--|---|--|--|--|
| 1. FOR STATE REGISTRAR  |  |   |  | 2a. DATE OF DEATH MONTH DAY YEAR  |  |  |  |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br><b>MOWBRAY, Mary E.</b>   |  |   |  | 2b. HOUR<br><b>6:15</b> M   |  |  |  |
| 3. SEX<br><b>FEMALE</b>   |  | 4. RACE<br><b>WHITE</b>   |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>11 - 11 - 01</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY) YRS<br><b>78</b>   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Md.</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U S A</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.  |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>ST. AGNES HOSPITAL</b> |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>HOUSEWIFE</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>BALTIMORE</b>   |  |   |  | 13b. COUNTY<br><b>MARYLAND</b>  |  | 13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                       |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>UNKNOWN</b>   |  |   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>UNKNOWN</b>  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br><b>NO</b>  |  |   |  | 16b. SOCIAL SECURITY NO.<br><b>UNKNOWN</b>  |  | 17. INFORMANT ADDRESS<br><b>Roston R. Mowbray 131 Collins Ave</b>  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiac arrest</b><br>4292<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>ASCVD</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |   |  |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____   |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION<br><b>NONE</b>   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |   |  |   |  |  |  |
| 22b. SIGNATURE<br><b>Anthony A. ARZ</b>   |  |   |  | DEGREE<br><b>MD</b>   |  | 22c. DATE SIGNED<br><b>12/16/79</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Anthony A. ARZ</b>  |  |   |  | 22e. ADDRESS<br><b>St. Agnes Hospital, Balt. Md.</b>  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>burial</b>  |  | 23b. DATE<br><b>12-19-79</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Meadow Ridge Mem. Pk.</b>  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><b>Baltimore Md.</b>  |  |
| 24. FUNERAL DIRECTOR NAME<br><b>J.T. Stansbury</b>  |  |   |  | ADDRESS<br><b>6411 Windsor Mill Rd, Balt, Md.</b>   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>DEC 17 1979</b>  |  |
|   |  |   |  | 25b. REGISTRAR'S SIGNATURE<br><b>Roston R. Mowbray</b>  |  |  |  |





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

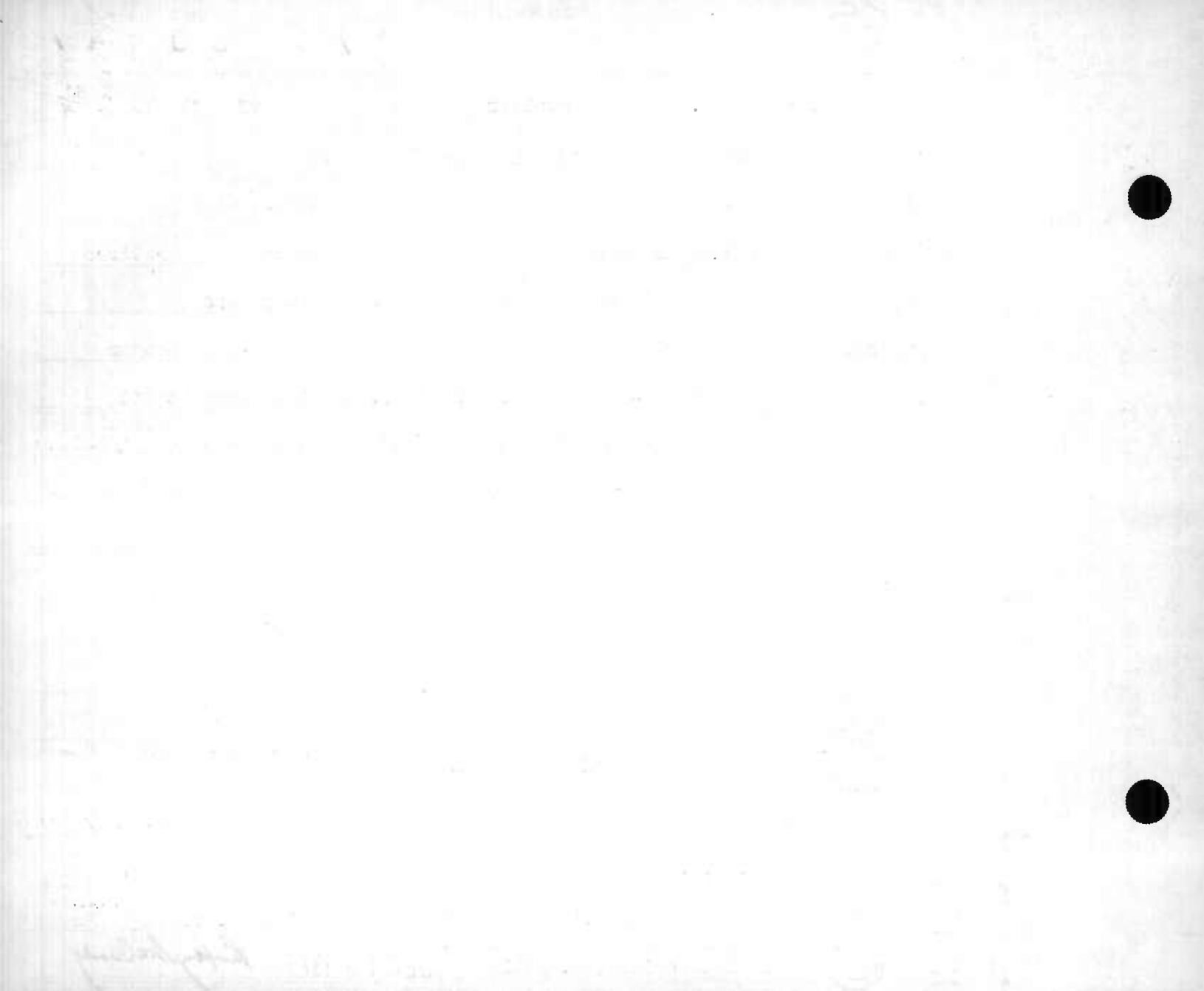
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

7 9 3 0 4 4 7

|  |  |  |  |   |   |  |   |  |  |  |  |
|--|--|--|--|---|---|--|---|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>DeVerne C. Mueller  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>12 17 79                        |   |   | 2b. HOUR<br>2:30 A M   |   |  |  |  |  |
| 3. SEX<br>Male   |  | 4. RACE<br>White   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>12 25 07  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>71 YRS.   |   |  |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.   |   |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>52 Upmanor Road |  |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Insurance  |   | 12b. KIND OF BUSINESS OR INDUSTRY<br>Retired   |  |  |  |
| 13a. STATE<br>Md   |  |  | 13b. COUNTY<br>Baltimore   |   | 13c. CITY OR TOWN<br>Baltimore                          |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br>52 Upmanor Road |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Frederick Mueller  |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Alice Hooper   |   |  |   |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No   |  |  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>215-07-8031  |   | 17. INFORMANT<br>ADDRESS<br>Mrs. Loretta E. Mueller Same as #13  |   |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Respirated abd aneurysm</u><br><u>4413</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Atherosclerosis</u><br>CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |  |  |  |   |   |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>instantaneous</u><br><u>unknown</u>                                     |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)  |  |  |  |   |   |  |   |  |  |  |  |
| 19a. DATE OF OPERATION   |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |   |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |   |  |  |  |  |
| 22a. I certify that (I) (this health officer) attended the deceased from <u>2/13</u> , 19 <u>61</u> , to <u>12/17</u> , 19 <u>79</u> , that (I) (we) last saw the deceased alive on <u>12/14</u> , 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.                           |  |  |  |   |   |  |   |  |  |  |  |
| 22b. SIGNATURE<br><u>Cliff Ratliff, Jr.</u>  |  |  |  |   |   | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |   |  | 22c. DATE SIGNED<br>12/17/79           |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Cliff Ratliff, Jr. M.D.   |  |  |  |   |   | 22e. ADDRESS<br>5772 Westview Mall Catonsville, Md. 21228  |   |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial   |  |  | 23b. DATE<br>12/20/79  |   | 23c. NAME OF CEMETERY OR CREMATORY<br>Lakeview Cemetery |  |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Sykesville Carroll Md  |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br>Witzke Funeral Home of Catonsville<br>1630 Edmondson Avenue Catonsville, Md. 21228   |  |  |  |   |   | 25a. DATE REC'D. BY REGISTRAR<br>DEC 18 1979   |   | 25b. REGISTRAR'S SIGNATURE<br><u>Henry McCreedy</u>  |  |  |  |



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED. WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| FOR<br>1- STATE REGISTRAR  |  |                  |  |   |  |   |  |   |  | DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH                  |  |  |  |   |  |  |  |  |  | REG. NO. 7 9 3 0 4 4 8 |  |                |  |
|--|--|------------------|--|---|--|---|--|---|--|---|--|--|--|---|--|--|--|--|--|------------------------|--|----------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) FIRST MIDDLE LAST<br>Jerome V. Mullally  |  |                  |  |   |  |   |  |   |  | 2a. DATE KNOWN OF DEATH<br>ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR<br>12 26 79 |  |  |  |   |  |  |  |  |  | 2b. HOUR<br>6:05       |  |                |  |
| 3. SEX<br>male   |  | 4. RACE<br>white |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>Oct 23, 1916  |  | 6. AGE (IN YEARS)<br>LAST BIRTHDAY<br>63 YRS.   |  | IF UNDER 1 YR.<br>MONTHS DAYS   |  | IF UNDER 24 HRS.<br>HOURS MIN   |  | 2c. DATE PRONOUNCED DEAD<br>MONTH DAY YEAR<br>12 26 19 79    |  |   |  |  |  |  |  |                        |  | 2d. HOUR<br>a. |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>New York  |  |                  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |  |   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  |   |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.   |  |   |  |  |  |  |  |                        |  |                |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore   |  |                  |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Union Memorial Hospital |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Retired  |  |   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>U S Army                |  |   |  |  |  |  |  |                        |  |                |  |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |                  |  |   |  |   |  |   |  |   |  |  |  |   |  |  |  |  |  |                        |  |                |  |
| 13a. STATE<br>Maryland   |  | 13b. COUNTY      |  | 13c. CITY OR TOWN<br>Baltimore  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br>823 N 33rd St.   |  |   |  |  |  |   |  |  |  |  |  |                        |  |                |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Unknown  |  |                  |  |   |  |   |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Catherine Begold                                   |  |  |  |   |  |  |  |  |  |                        |  |                |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br>Yes   |  |                  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE YEAR OR DATES)<br>1937-1962   |  | 17. INFORMANT<br>ADDRESS<br>Patricia McGill 9915 Kingsbridge Dr. Fairfax, Va.                   |  |   |  |   |  |  |  |   |  |  |  |  |  |                        |  |                |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease<br>4292<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b)<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)   |  |                  |  |   |  |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |  |  |   |  |  |  |  |  |                        |  |                |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).  |  |                  |  |   |  |   |  |   |  |   |  |  |  |   |  |  |  |  |  |                        |  |                |  |
| 19a. DATE OF OPERATION   |  |                  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |  |   |  |   |  |   |  |  |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |  |  |                        |  |                |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |  |                  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |  |   |  |  |  |   |  |  |  |  |  |                        |  |                |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK  |  |                  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)   |  |   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |  |  |   |  |  |  |  |  |                        |  |                |  |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |  |                  |  |   |  |   |  |   |  |   |  |  |  |   |  |  |  |  |  |                        |  |                |  |
| ACTUAL SIGNATURE<br>Hormez R. Guard, M.D.  |  |                  |  | TITLE (SPECIFY)<br>Assistant  |  |   |  | DATE SIGNED<br>12/26/79   |  |   |  |  |  |   |  |  |  |  |  |                        |  |                |  |
| EXAMINER'S NAME (TYPE OR PRINT)  |  |                  |  | ADDRESS<br>111 Penn Street, Balto., MD 21201  |  |   |  |   |  |   |  |  |  |   |  |  |  |  |  |                        |  |                |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial  |  |                  |  | 23b. DATE<br>Dec 31, 1979   |  |   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Arlington Nat. Cem.   |  |   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Arlington, Va. |  |   |  |  |  |  |  |                        |  |                |  |
| 24. FUNERAL DIRECTOR NAME<br>Everly Funeral Home   |  |                  |  | 25a. DATE REC'D. BY REGISTRAR<br>DEC 31 1979  |  |   |  |   |  |   |  |  |  | 25b. REGISTRAR'S SIGNATURE<br>Hormez R. Guard                                       |  |  |  |  |  |                        |  |                |  |



THE  
MAY

1950

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

7 9 3 0 4 4 9

REG. NO.

1. FOR  
STATE  
REGISTRAR

|  |  |  |   |   |   |  |   |  |  |  |
|--|--|--|---|---|---|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Charles T. Mullen, Sr.</b>   |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>12 15 79</b>                    |   |   | 2b. HOUR<br><b>M</b>   |   |  |  |  |
| 3. SEX<br><b>M</b>   |  | 4. RACE<br><b>B</b>  |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>12 25 29</b>   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>49</b> YRS.  |   | 7. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.   |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Md.</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.  |   |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Balto.</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>4808 Lorelley Avenue</b> |   |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)   |   | 12b. KIND OF BUSINESS OR INDUSTRY  |  |  |
| 13a. STATE<br><b>Md.</b>   |  |  | 13b. COUNTY   |   | 13c. CITY OR TOWN<br><b>Balto.</b>                                    |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>4808 Lorelley Ave.</b> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Thomas C. Mullens</b>   |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Rosebud Patterson</b> |   |   |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>Yes</b>   |  |  | 16b. SOCIAL SECURITY NO.<br><b>215-24-3515</b>                            |   | 17. INFORMANT<br>ADDRESS<br><b>Margaret Mullen 4808 Lorelley Ave.</b> |  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cancer of the Lung</b><br>1629<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>DUE TO, OR AS A CONSEQUENCE OF (b)<br>DUE TO, OR AS A CONSEQUENCE OF (c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>15 months</b> |  |  |   |   |   |  |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):<br><b>Heart Failure 20% Aortic &amp; Mitral Valve Disease, Diabetes, Chronic Pancreatitis</b>   |  |  |   |   |   |  |   |  |  |  |
| 19a. DATE OF OPERATION<br><b>N/A</b>   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |   |  |   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |  |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>Dec 5</b> , 19 <b>79</b> , to <b>Dec 5</b> , 19 <b>79</b> , that (I) (we) last saw the deceased alive on <b>Dec 5</b> , 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |  |   |   |   |  |   |  |  |  |
| 22b. SIGNATURE<br><b>Robert W. Peters</b>  |  |  |   | DEGREE<br><b>MD</b>   |   | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |   | 22c. DATE SIGNED<br><b>12/19/79</b>  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Robert W. Peters</b>   |  |  |   | 22e. ADDRESS<br><b>Cardiology Dept<br/>VA Hospital, 3900 Loch Raven Blvd, Balt, Md</b>  |   |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>12/22/79</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Arbutus Mem. Pk</b>  |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Arbutus Md</b>  |   |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Wm C March F/H 1101 E. North Ave.</b>   |  |  |   | 25a. DATE REC'D. BY REGISTRAR<br><b>DEC 20 1979</b>   |   | 25b. REGISTRAR'S SIGNATURE<br><b>Ricky Halbury</b>   |   |  |  |  |

MEDICAL CERTIFICATION

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, part should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.



Handwritten signature or initials in the bottom left corner.

Handwritten text, possibly a date or reference number, located below the signature.

Handwritten text, possibly a name or title, located in the lower right area.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 13 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| FOR<br>STATE<br>REGISTRAR   |  |  |  | STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  | 7 9 3 0 4 5 0<br>REG. NO.  |  |                                   |  |
|---|--|--|--|--|--|---|--|--|--|-----------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>CHARLES H. MULLER</b>   |  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>12 03 79</b>   |  |   |  | 2b. HOUR<br><b>10:47<sup>A</sup></b>   |  |                                   |  |
| 3. SEX<br><b>MALE</b>   |  | 4. RACE<br><b>WHITE</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>06 10 03</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>76</b> YRS.   |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS  |  | 8. IF UNDER 24 HRS.<br>HOURS MIN. |  |
| 9a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MARYLAND</b>  |  | 9b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 10. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.                               |  |  |  |                                   |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>ST. AGNES HOSPITAL</b> |  |  |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>PURCHASING AGT.</b>      |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>WATER DEPT.,</b>   |  |                                   |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>MARYLAND</b>   |  | 13b. COUNTY<br><b>BALTIMORE</b>  |  | 13c. CITY OR TOWN<br><b>WESTVIEW</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>BALTO. CITY<br/>1116 WILSON AVENUE, 21207</b>  |  |                                   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>MICHAEL MULLER</b>   |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>DORA TEVES</b>   |  |   |  |  |  |                                   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>   |  | 16b. SOCIAL SECURITY NO<br>(IF YES, GIVE WAR OR DATES)<br><b>218-18-2798</b>   |  | 17. INFORMANT<br><b>MARY MULLER, 1116 WILSON AVENUE, 21207</b>   |  |   |  | ADDRESS  |  |                                   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiorespiratory arrest.</b><br><b>4140</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(b) <b>Atherosclerotic Heart Disease</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) |  |  |  |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |                                   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |  |  |  |  |   |  |  |  |                                   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |                                   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |   |  |  |  |                                   |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |   |  |  |  |                                   |  |
| 22. I certify that (I) (this hospital) attended the deceased from <b>12-3-79</b> , to <b>12-3-79</b> , that (I) (we) lost saw the deceased alive on <b>12-3-79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.   |  |  |  |  |  |   |  |  |  |                                   |  |
| 22b. SIGNATURE<br><b>Chander Maholtra</b>   |  |  |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>         |  |   |  | 22c. DATE SIGNED<br><b>12-3-79</b>   |  |                                   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>CHANDER MAHOLTRA, M.D.</b>  |  |  |  | 22e. ADDRESS<br><b>900 CATON AVE. BALTIMORE, MD. 21229</b>   |  |   |  |  |  |                                   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>BURIAL</b>  |  | 23b. DATE<br><b>12-06-79</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>MEADOWRIDGE MEM. PK.</b>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>ELKRIDGE HOWARD MARYLAND</b>                   |  |  |  |                                   |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>HUBBARD FUNERAL HOME, INC., 4107 WILKENS AVE.</b>  |  |  |  | 25. DATE REC'D. BY REGISTRAR<br><b>DEC 5 1979</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>  |  |  |  |                                   |  |

BALTIMORE CITY

ST. AGNES HOSPITAL

BALTIMORE

BALTIMORE

DATE

CHANDLER HANCOCK, M.D.

1952



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 7 days after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| FOR<br>1 - STATE<br>REGISTRAR  |                         | STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH |  | 7 9 3 0 4 5 1<br>REG. NO.   |  |
|--|-------------------------|--|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>ALICE P MURRAY</b>  |                         | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>12-24-79</b>                               |  | 2b. HOUR<br><b>8:08 AM</b>  |  |
| 3. SEX<br><b>Female</b>  | 4. RACE<br><b>White</b> | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>March 29, 1896</b>                          |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>83</b> YRS.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Connecticut</b>  |                         | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U S A</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>  |                         | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br><b>ST AGNES HOSPITAL</b>  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.   |  |
| 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Housewife</b>   |                         | 12b. KIND OF BUSINESS OR INDUSTRY  |  |   |  |
| 13a. STATE<br><b>Maryland</b>  |                         | 13b. COUNTY<br><b>Baltimore</b>  |  | 13c. CITY OR TOWN<br><b>Catonsville</b>   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>John O'Brien</b>  |                         | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Bridget Layden</b>               |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>no</b>   |                         | 16b. SOCIAL SECURITY NO.<br><b>214-24-7577</b>                                       |  | 17. INFORMANT<br>ADDRESS<br><b>Miss Alice Murray, 1915 Clifden Road</b>   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiac arrhythmia</b><br><b>4292</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>arteriosclerotic cardiovascular disease</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>yes</b> |                         | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>moments</b>                       |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |                         |  |  |   |  |
| 19a. DATE OF OPERATION   |                         | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                     |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |                         | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                           |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |                         | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)               |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |
| 22a. I certify that (1) <del>this hospital</del> attended the deceased from <b>12-24</b> , 19 <b>76</b> , to <b>12-24</b> , 19 <b>79</b> , that (we) lost <b>above</b> the deceased alive on <b>12-24</b> , 19 <b>79</b> , and that in <del>my</del> (our) opinion death occurred on the date and hour and from the causes stated above.   |                         |  |  |   |  |
| 22b. SIGNATURE<br><b>Lawrence R. Gallager, MD</b>  |                         | DEGREE<br><b>MD</b>  |  | 22c. DATE SIGNED<br><b>12-24-79</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>L. GALLAGER</b>  |                         | 22e. ADDRESS<br><b>ST AGNES MED CTR, BALTO., MD.</b>                                 |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |                         | 23b. DATE<br><b>12/27/79</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Crestlawn Cemetery</b>   |  |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Marriottsville, Howard, Md.</b>   |                         | 24. FUNERAL DIRECTOR<br>NAME<br><b>1630 Edmondson Ave., Catonsville, Md</b>          |  | 25a. DATE REC'D. BY REGISTRAR<br><b>DEC 26 1979</b>   |  |
| 25b. REGISTRAR'S SIGNATURE<br><b>Witzke Funeral Home of Catonsville P.A. 21226</b>   |                         |  |  |   |  |

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BALTIMORE CITY

BALTIMORE ST AGNES HOSPITAL



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**TO MEDICAL EXAMINER:** THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGES 1, 2, AND 3 FOR YOUR FILES.

**TO FUNERAL DIRECTOR:** PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 300 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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| STATE OF MARYLAND  |                         |   |  |   |  |   |  |   |  |  |  |                                   |  |   |  |   |                                     |  |                                     |
|--|-------------------------|---|--|---|--|---|--|---|--|--|--|-----------------------------------|--|---|--|---|-------------------------------------|--|-------------------------------------|
| DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |                         |   |  |   |  |   |  |   |  |  |  |                                   |  |   |  |   |                                     |  |                                     |
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |                         |   |  |   |  |   |  |   |  |  |  |                                   |  |   |  |   |                                     |  |                                     |
| FOR<br>1- STATE REGISTRAR  |                         | REG. NO. 30452  |  |   |  |   |  |   |  |  |  |                                   |  |   |  |   |                                     |  |                                     |
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |                         | FIRST<br><b>Irvin</b>   |  |   |  | MIDDLE<br><b>H</b>  |  |   |  | LAST<br><b>Murray</b>  |  |                                   |  | 2a. DATE KNOWN OF DEATH   |  | <input checked="" type="checkbox"/> ESTIMATED | MONTH DAY YEAR<br><b>12 1 19 79</b> |  | 2b. HOUR MINUTE<br><b>3:05 a.m.</b> |
| 3. SEX<br><b>male</b>  | 4. RACE<br><b>black</b> | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>6 15 10</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>69 YRS.</b>                 |  | IF UNDER 1 YR.<br>MONTHS DAYS   |  | IF UNDER 24 HRS.<br>HOURS MIN   |  | 2c. DATE PRONOUNCED DEAD<br><b>12 1 19 79</b>                                |  |                                   |  |   |  |   |                                     |  |                                     |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>   |                         | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U. S. A.</b>   |  |   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  |   |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b>                |  |                                   |  |   |  |   |                                     |  |                                     |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |                         | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Mercy Hospital</b> |  |   |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                 |  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY |  |   |  |   |                                     |  |                                     |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |                         |   |  |   |  |   |  |   |  |  |  |                                   |  |   |  |   |                                     |  |                                     |
| 13a. STATE<br><b>Maryland</b>  |                         | 13b. COUNTY   |  | 13c. CITY OR TOWN<br><b>Baltimore</b>                             |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 13e. STREET ADDRESS<br><b>2533 Boyd Street</b>                                |  |  |  |                                   |  |   |  |   |                                     |  |                                     |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Henry Murray</b>  |                         |   |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Lottie</b>  |  |   |  |  |  |                                   |  |   |  |   |                                     |  |                                     |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>No</b>  |                         |   |  | 16b. SOCIAL SECURITY NO.<br><b>218-10-5223</b>                    |  |   |  | 17. INFORMANT ADDRESS<br><b>Rita Tyler 2533 Boyd Street</b>                   |  |  |  |                                   |  |   |  |   |                                     |  |                                     |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I DEATH WAS CAUSED BY:<br><b>Arteriosclerotic cardiovascular disease</b><br>IMMEDIATE CAUSE (a) <b>4392</b><br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____  |                         |   |  |   |  |   |  |   |  |  |  |                                   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |                                     |  |                                     |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).  |                         |   |  |   |  |   |  |   |  |  |  |                                   |  |   |  |   |                                     |  |                                     |
| 19a. DATE OF OPERATION   |                         |   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                 |  |   |  |   |  |  |  |                                   |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |   |                                     |  |                                     |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |                         |   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b> |  |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) |  |  |  |                                   |  |   |  |   |                                     |  |                                     |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |                         |   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)       |  |   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                             |  |  |  |                                   |  |   |  |   |                                     |  |                                     |
| 22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion |                         |   |  |   |  |   |  |   |  |  |  |                                   |  |   |  |   |                                     |  |                                     |
| ACTUAL SIGNATURE<br><i>[Signature]</i>   |                         |   |  | TITLE (SPECIFY)<br><b>Assistant</b>                               |  |   |  | MEDICAL EXAMINER  |  |  |  | DATE SIGNED<br><b>12/2/79</b>     |  |   |  |   |                                     |  |                                     |
| EXAMINER'S NAME<br>(TYPE OR PRINT)<br><b>Margarita A. Korell, MD.</b>  |                         |   |  | ADDRESS<br><b>111 Penn Street, Balto., MD 21201</b>               |  |   |  |   |  |  |  |                                   |  |   |  |   |                                     |  |                                     |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |                         |   |  | 23b. DATE<br><b>12/6/1979</b>                                     |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>King Memorial Park</b>   |  |   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Co., Maryland</b> |  |                                   |  |   |  |   |                                     |  |                                     |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Wm. C. March F/H 1101 East North Avenue</b>   |                         |   |  |   |  |   |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>DEC 4 1979</b>                           |  |                                   |  | 25b. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>                                    |  |   |                                     |  |                                     |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  |   |  |  |                        |   |  |
|---|--|---|--|---|--|--|------------------------|---|--|
| 1. FOR STATE REGISTRAR / <b>NATHANIEL</b>   |  | REG. NO. <b>7 9 3 0 4 5 3</b>   |  |   |  |  |                        |   |  |
| 1. DECEASED NAME (TYPE OR PRINT) <b>2 ( NATHANIEL ) MURRAY</b>  |  |   |  |   | 2a. DATE OF DEATH MONTH <b>12</b> DAY <b>12</b> YEAR <b>79</b> |  | 2b. HOUR <b>12:00P</b> |   |  |
| 3. SEX <b>MALE</b>  |  | 4. RACE <b>BLACK</b>  |  | 5. DATE OF BIRTH MONTH <b>10</b> DAY <b>5</b> YEAR <b>29</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY) <b>50</b> YRS.   |                        | IF UNDER 1 YEAR MONTHS <b></b> DAYS <b></b> IF UNDER 74 HRS. HOURS <b></b> MIN. <b></b>                                 |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>NORTH CAROLINA</b>   |  | 7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>    |  | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY</b> MD.                               |                        |   |  |
| 10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>VA MEDICAL CENTER BALTO.MD.</b> |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                                |                        | 12b. KIND OF BUSINESS OR INDUSTRY   |  |
| 13a. STATE <b>MARYLAND</b>  |  | 13b. COUNTY <b></b>   |  | 13c. CITY OR TOWN <b>BALTIMORE</b>  |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                        | 13e. STREET ADDRESS <b>3212 Barclay Street 21218</b>  |  |
| 14. FATHER'S NAME FIRST <b>John N.</b> MIDDLE <b></b> LAST <b>Murray</b>  |  |   |  | 15. MOTHER'S MAIDEN NAME FIRST <b>Mary</b> MIDDLE <b>A.</b> LAST <b>McIntyre</b>  |  |  |                        |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>YES</b>  |  | 16b. SOCIAL SECURITY NO. <b>KOREAN</b>  |  | 17. INFORMANT ADDRESS <b>Beatrice Murray 3212 Barclay Street</b>  |  |  |                        |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Cardio Respiratory Distress</b>   |  |   |  |   |  |  |                        |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| 303-<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>Neurorenal Syndrome &amp; Hepatic encephalopathy.</b>   |  |   |  |   |  |  |                        |   |  |
| DUE TO, OR AS A CONSEQUENCE OF (c) <b>Alcoholism</b>  |  |   |  |   |  |  |                        |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |   |  |   |  |  |                        |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |                        | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |                        |   |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |  |                        |   |  |
| 22a. I certify that (X) (this hospital) attended the deceased from <b>NOV. 29</b> , 19 <b>79</b> , to <b>DEC. 12</b> , 19 <b>79</b> , that (X) (we) last saw the deceased alive on <b>DEC. 12</b> , 19 <b>79</b> , and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (we) (did) <del>not</del> view the body after death. |  |   |  |   |  |  |                        |   |  |
| 22b. SIGNATURE <b>Lisa M. Bookert MD</b>  |  |   |  | DEGREE <b>MD</b> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  |  |                        | 22c. DATE SIGNED <b>12/12/79</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>LISA M. Bookert MD</b>   |  |   |  | 22e. ADDRESS <b>Univ. of Md. Family Practice</b>  |  |  |                        |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>   |  | 23b. DATE <b>12/17/1979</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY <b>King Memorial Park</b>  |  | 23d. LOCATION CITY OR TOWN <b>Baltimore Co., Maryland</b> COUNTY STATE                       |                        |   |  |
| 24. FUNERAL DIRECTOR NAME <b>Wm. C. March F/H</b> ADDRESS <b>1101 East North Avenue</b>   |  |   |  | 25. DATE RECD. BY REGISTRAR <b>DEC 3 1979</b>   |  | 25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>  |                        |   |  |

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

## MEDICAL CERTIFICATION

| FOR STATE REGISTRAR   |  |  |  |  |  |  |  |  |  | DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |  |  |  |  |  |  |  |  | MEDICAL EXAMINER'S CERTIFICATE OF DEATH                                       |  |  |  |  |  |  |  |  |  | REG. NO. 30454  |  |  |  |  |  |  |  |  |  |                                      |  |  |  |  |  |  |  |  |  |                  |  |  |  |  |  |  |  |  |  |                          |  |  |  |  |  |  |  |  |  |          |  |  |  |  |  |  |  |  |  |
|---|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|---|--|--|--|--|--|--|--|--|--|---|--|--|--|--|--|--|--|--|--|--------------------------------------|--|--|--|--|--|--|--|--|--|------------------|--|--|--|--|--|--|--|--|--|--------------------------|--|--|--|--|--|--|--|--|--|----------|--|--|--|--|--|--|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT)  |  |  |  |  |  |  |  |  |  | FIRST MIDDLE LAST  |  |  |  |  |  |  |  |  |  | 2a. DATE KNOWN OF DEATH   |  |  |  |  |  |  |  |  |  | 2b. HOUR  |  |  |  |  |  |  |  |  |  |                                      |  |  |  |  |  |  |  |  |  |                  |  |  |  |  |  |  |  |  |  |                          |  |  |  |  |  |  |  |  |  |          |  |  |  |  |  |  |  |  |  |
| BRODERICK ANTHONY MUSE  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | 12 9 1979   |  |  |  |  |  |  |  |  |  | M   |  |  |  |  |  |  |  |  |  |                                      |  |  |  |  |  |  |  |  |  |                  |  |  |  |  |  |  |  |  |  |                          |  |  |  |  |  |  |  |  |  |          |  |  |  |  |  |  |  |  |  |
| 3. SEX  |  |  |  |  |  |  |  |  |  | 4. RACE  |  |  |  |  |  |  |  |  |  | 5. DATE OF BIRTH  |  |  |  |  |  |  |  |  |  | 6. AGE (IN YEARS)   |  |  |  |  |  |  |  |  |  | IF UNDER 1 YR.                       |  |  |  |  |  |  |  |  |  | IF UNDER 24 HRS. |  |  |  |  |  |  |  |  |  | 2c. DATE PRONOUNCED DEAD |  |  |  |  |  |  |  |  |  | 2d. HOUR |  |  |  |  |  |  |  |  |  |
| male  |  |  |  |  |  |  |  |  |  | negro  |  |  |  |  |  |  |  |  |  | 11 8 54   |  |  |  |  |  |  |  |  |  | 25  |  |  |  |  |  |  |  |  |  |                                      |  |  |  |  |  |  |  |  |  |                  |  |  |  |  |  |  |  |  |  | 12 9 1979                |  |  |  |  |  |  |  |  |  | 8a M     |  |  |  |  |  |  |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  |  |  |  |  |  |  |  |  | 7b. CITIZEN OF WHAT COUNTRY?   |  |  |  |  |  |  |  |  |  | 8. MARRIED  |  |  |  |  |  |  |  |  |  | NEVER MARRIED   |  |  |  |  |  |  |  |  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH |  |  |  |  |  |  |  |  |  | MD.              |  |  |  |  |  |  |  |  |  |                          |  |  |  |  |  |  |  |  |  |          |  |  |  |  |  |  |  |  |  |
| Maryland  |  |  |  |  |  |  |  |  |  | U. S. A.   |  |  |  |  |  |  |  |  |  | WIDOWED   |  |  |  |  |  |  |  |  |  | DIVORCED  |  |  |  |  |  |  |  |  |  | Baltimore City                       |  |  |  |  |  |  |  |  |  |                  |  |  |  |  |  |  |  |  |  |                          |  |  |  |  |  |  |  |  |  |          |  |  |  |  |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH   |  |  |  |  |  |  |  |  |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION   |  |  |  |  |  |  |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                 |  |  |  |  |  |  |  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY                                   |  |  |  |  |  |  |  |  |  |                                      |  |  |  |  |  |  |  |  |  |                  |  |  |  |  |  |  |  |  |  |                          |  |  |  |  |  |  |  |  |  |          |  |  |  |  |  |  |  |  |  |
| Baltimore   |  |  |  |  |  |  |  |  |  | Sinai Hospital   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |                                      |  |  |  |  |  |  |  |  |  |                  |  |  |  |  |  |  |  |  |  |                          |  |  |  |  |  |  |  |  |  |          |  |  |  |  |  |  |  |  |  |
| 13a. STATE  |  |  |  |  |  |  |  |  |  | 13b. COUNTY  |  |  |  |  |  |  |  |  |  | 13c. CITY OR TOWN   |  |  |  |  |  |  |  |  |  | 13d. INSIDE CITY LIMITS?  |  |  |  |  |  |  |  |  |  | 13e. STREET ADDRESS                  |  |  |  |  |  |  |  |  |  |                  |  |  |  |  |  |  |  |  |  |                          |  |  |  |  |  |  |  |  |  |          |  |  |  |  |  |  |  |  |  |
| Maryland  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | Baltimore   |  |  |  |  |  |  |  |  |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  |  |  |  |  |  |  |  | 3509 Hayward Avenue                  |  |  |  |  |  |  |  |  |  |                  |  |  |  |  |  |  |  |  |  |                          |  |  |  |  |  |  |  |  |  |          |  |  |  |  |  |  |  |  |  |
| 14. FATHER'S NAME   |  |  |  |  |  |  |  |  |  | 15. MOTHER'S MAIDEN NAME   |  |  |  |  |  |  |  |  |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?                                  |  |  |  |  |  |  |  |  |  | 16b. SOCIAL SECURITY NO.  |  |  |  |  |  |  |  |  |  | 17. INFORMANT                        |  |  |  |  |  |  |  |  |  | ADDRESS          |  |  |  |  |  |  |  |  |  |                          |  |  |  |  |  |  |  |  |  |          |  |  |  |  |  |  |  |  |  |
| Nathaniel   |  |  |  |  |  |  |  |  |  | Muse   |  |  |  |  |  |  |  |  |  | Emma  |  |  |  |  |  |  |  |  |  | Crenshaw  |  |  |  |  |  |  |  |  |  |                                      |  |  |  |  |  |  |  |  |  |                  |  |  |  |  |  |  |  |  |  |                          |  |  |  |  |  |  |  |  |  |          |  |  |  |  |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |  |  |  |  |  |  |  |  |  | 19a. DATE OF OPERATION   |  |  |  |  |  |  |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                             |  |  |  |  |  |  |  |  |  | 20. AUTOPSY?  |  |  |  |  |  |  |  |  |  |                                      |  |  |  |  |  |  |  |  |  |                  |  |  |  |  |  |  |  |  |  |                          |  |  |  |  |  |  |  |  |  |          |  |  |  |  |  |  |  |  |  |
| PART I DEATH WAS CAUSED BY:   |  |  |  |  |  |  |  |  |  | IMMEDIATE CAUSE (a) Cranio-cerebral injuries   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                        |  |  |  |  |  |  |  |  |  |                                      |  |  |  |  |  |  |  |  |  |                  |  |  |  |  |  |  |  |  |  |                          |  |  |  |  |  |  |  |  |  |          |  |  |  |  |  |  |  |  |  |
| 8147  |  |  |  |  |  |  |  |  |  | DUE TO, OR AS A CONSEQUENCE OF   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |                                      |  |  |  |  |  |  |  |  |  |                  |  |  |  |  |  |  |  |  |  |                          |  |  |  |  |  |  |  |  |  |          |  |  |  |  |  |  |  |  |  |
| Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.                                       |  |  |  |  |  |  |  |  |  | (b)  |  |  |  |  |  |  |  |  |  | DUE TO, OR AS A CONSEQUENCE OF  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |                                      |  |  |  |  |  |  |  |  |  |                  |  |  |  |  |  |  |  |  |  |                          |  |  |  |  |  |  |  |  |  |          |  |  |  |  |  |  |  |  |  |
|   |  |  |  |  |  |  |  |  |  | (c)  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |                                      |  |  |  |  |  |  |  |  |  |                  |  |  |  |  |  |  |  |  |  |                          |  |  |  |  |  |  |  |  |  |          |  |  |  |  |  |  |  |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |                                      |  |  |  |  |  |  |  |  |  |                  |  |  |  |  |  |  |  |  |  |                          |  |  |  |  |  |  |  |  |  |          |  |  |  |  |  |  |  |  |  |
| 21a. EXTERNAL CAUSE WAS   |  |  |  |  |  |  |  |  |  | 21b. TIME OF INJURY  |  |  |  |  |  |  |  |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |                                      |  |  |  |  |  |  |  |  |  |                  |  |  |  |  |  |  |  |  |  |                          |  |  |  |  |  |  |  |  |  |          |  |  |  |  |  |  |  |  |  |
| UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH                              |  |  |  |  |  |  |  |  |  | 9:30 P.M. 12-8-1979  |  |  |  |  |  |  |  |  |  | Pedestrian struck by auto.  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |                                      |  |  |  |  |  |  |  |  |  |                  |  |  |  |  |  |  |  |  |  |                          |  |  |  |  |  |  |  |  |  |          |  |  |  |  |  |  |  |  |  |
| 21d. INJURY OCCURRED  |  |  |  |  |  |  |  |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)  |  |  |  |  |  |  |  |  |  | 21f. LOCATION   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |                                      |  |  |  |  |  |  |  |  |  |                  |  |  |  |  |  |  |  |  |  |                          |  |  |  |  |  |  |  |  |  |          |  |  |  |  |  |  |  |  |  |
| WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>  |  |  |  |  |  |  |  |  |  | street   |  |  |  |  |  |  |  |  |  | 3300 blk. W. Belvedere Ave., Balto. City Md.                                  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |                                      |  |  |  |  |  |  |  |  |  |                  |  |  |  |  |  |  |  |  |  |                          |  |  |  |  |  |  |  |  |  |          |  |  |  |  |  |  |  |  |  |
| 22a. I certify that I took charge of the remains described above, held on   |  |  |  |  |  |  |  |  |  | Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |                                      |  |  |  |  |  |  |  |  |  |                  |  |  |  |  |  |  |  |  |  |                          |  |  |  |  |  |  |  |  |  |          |  |  |  |  |  |  |  |  |  |
| death resulted from:  |  |  |  |  |  |  |  |  |  | Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |                                      |  |  |  |  |  |  |  |  |  |                  |  |  |  |  |  |  |  |  |  |                          |  |  |  |  |  |  |  |  |  |          |  |  |  |  |  |  |  |  |  |
| ACTUAL SIGNATURE  |  |  |  |  |  |  |  |  |  | MARGARITA A. KORELL  |  |  |  |  |  |  |  |  |  | TITLE (SPECIFY)   |  |  |  |  |  |  |  |  |  | DATE SIGNED   |  |  |  |  |  |  |  |  |  |                                      |  |  |  |  |  |  |  |  |  |                  |  |  |  |  |  |  |  |  |  |                          |  |  |  |  |  |  |  |  |  |          |  |  |  |  |  |  |  |  |  |
|   |  |  |  |  |  |  |  |  |  | M.D.   |  |  |  |  |  |  |  |  |  | Assistant   |  |  |  |  |  |  |  |  |  | 12-10-79  |  |  |  |  |  |  |  |  |  |                                      |  |  |  |  |  |  |  |  |  |                  |  |  |  |  |  |  |  |  |  |                          |  |  |  |  |  |  |  |  |  |          |  |  |  |  |  |  |  |  |  |
| EXAMINER'S NAME (TYPE OR PRINT)   |  |  |  |  |  |  |  |  |  | Margarita A. Korell, M.D.  |  |  |  |  |  |  |  |  |  | ADDRESS   |  |  |  |  |  |  |  |  |  | 111 Penn St.  |  |  |  |  |  |  |  |  |  |                                      |  |  |  |  |  |  |  |  |  |                  |  |  |  |  |  |  |  |  |  |                          |  |  |  |  |  |  |  |  |  |          |  |  |  |  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   |  |  |  |  |  |  |  |  |  | 23b. DATE  |  |  |  |  |  |  |  |  |  | 23c. NAME OF CEMETERY OR CREMATORY  |  |  |  |  |  |  |  |  |  | 23d. LOCATION   |  |  |  |  |  |  |  |  |  |                                      |  |  |  |  |  |  |  |  |  |                  |  |  |  |  |  |  |  |  |  |                          |  |  |  |  |  |  |  |  |  |          |  |  |  |  |  |  |  |  |  |
| Burial  |  |  |  |  |  |  |  |  |  | 12/13/1979   |  |  |  |  |  |  |  |  |  | Mount Auburn Cemetery   |  |  |  |  |  |  |  |  |  | Baltimore, Maryland   |  |  |  |  |  |  |  |  |  |                                      |  |  |  |  |  |  |  |  |  |                  |  |  |  |  |  |  |  |  |  |                          |  |  |  |  |  |  |  |  |  |          |  |  |  |  |  |  |  |  |  |
| 24. FUNERAL DIRECTOR  |  |  |  |  |  |  |  |  |  | 25a. DATE REC'D. BY REGISTRAR  |  |  |  |  |  |  |  |  |  | 25b. REGISTRAR'S SIGNATURE  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |                                      |  |  |  |  |  |  |  |  |  |                  |  |  |  |  |  |  |  |  |  |                          |  |  |  |  |  |  |  |  |  |          |  |  |  |  |  |  |  |  |  |
| NAME  |  |  |  |  |  |  |  |  |  | ADDRESS  |  |  |  |  |  |  |  |  |  | DEC 11 1979   |  |  |  |  |  |  |  |  |  | T. J. McCreedy  |  |  |  |  |  |  |  |  |  |                                      |  |  |  |  |  |  |  |  |  |                  |  |  |  |  |  |  |  |  |  |                          |  |  |  |  |  |  |  |  |  |          |  |  |  |  |  |  |  |  |  |
| Wm. C. March F/H 1101 East North Avenue   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |                                      |  |  |  |  |  |  |  |  |  |                  |  |  |  |  |  |  |  |  |  |                          |  |  |  |  |  |  |  |  |  |          |  |  |  |  |  |  |  |  |  |



7.2

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DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 30455

|  |  |  |  |  |  |  |  |
|--|--|--|--|--|--|--|--|
| 1- FOR STATE REGISTRAR   |  | 2a. DATE KNOWN OF DEATH  |  | MONTH DAY YEAR   |  | 2b. HOUR   |  |
| 1. DECEASED NAME (TYPE OR PRINT)   |  | FIRST  |  | MIDDLE   |  | LAST   |  |
| (Lizzie) ELIZABETH   |  | T.   |  | MUSE   |  |  |  |
| 3. SEX   |  | 4. RACE  |  | 5. DATE OF BIRTH   |  | 6. AGE (IN YEARS)  |  |
| female   |  | black  |  | Feb. 9, 1914   |  | 65   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH   |  |
| Virginia   |  | U.S.A.   |  |  |  | Baltimore City   |  |
| 10. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| Baltimore  |  | 1625 Moreland Avenue   |  | House Wife   |  | -----0-----  |  |
| 13a. STATE   |  | 13b. COUNTY  |  | 13c. CITY OR TOWN  |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| Md.  |  |  |  | Baltimore  |  | 1625 Moreland Ave.   |  |
| 14. FATHER'S NAME  |  | 15. MOTHER'S MAIDEN NAME   |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)   |  | 16b. SOCIAL SECURITY NO.   |  |
| Henry Haskins  |  | Unknown  |  | -----0-----  |  | 219-16-5956  |  |
| 17. INFORMANT  |  | ADDRESS  |  | 17a. DATE OF OPERATION   |  | 17b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |  |
| Clarence Muse  |  | 1625 Moreland Ave.   |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  | 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |  |
| PART I DEATH WAS CAUSED BY: Arteriosclerotic cardiovascular disease  |  |  |  |  |  |  |  |
| IMMEDIATE CAUSE (a) 4292   |  |  |  |  |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF   |  |  |  |  |  |  |  |
| (b)  |  |  |  |  |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF   |  |  |  |  |  |  |  |
| (c)  |  |  |  |  |  |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).  |  |  |  |  |  |  |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)  |  | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>             |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |  |  |
| 22a. I certify that I took charge of the remains described above, held on death resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |  | Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> |  | and in my opinion  |  |  |  |
| ACTUAL SIGNATURE <u>Margarita A. Korell</u>  |  | TITLE (SPECIFY) Assistant  |  | DATE SIGNED 12/7/79  |  |  |  |
| EXAMINER'S NAME (TYPE OR PRINT) Margarita A. Korell, M.D.  |  | ADDRESS 111 Penn Street  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE  |  |
| Burial   |  | 12/10/79   |  | Carver Mem. Pk.  |  | Laurel Maryland  |  |
| 24. FUNERAL DIRECTOR NAME  |  | 25a. DATE REC'D. BY REGISTRAR  |  | 25b. REGISTRAR'S SIGNATURE   |  |  |  |
| Law Funeral Home 4611 Park Heights Ave.  |  | DEC 11 1979  |  | <u>Esther Helms</u>  |  |  |  |

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

THE UNIVERSITY OF CHICAGO

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Chlorophyll *a* and *b* were determined using a spectrophotometer.

1000 Broadway Ave.

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07/11/79 - Carver Linn. Co. - Laurel Marshland

Leicht Ave.





85 82 P81 1 110014  
KNOX HOSPITAL  
NOV 24 11

November 21, 1943  
Washington

Dear Sir:  
The following information was received from the  
Washington Field Office on November 19, 1943:  
The following information was received from the  
Washington Field Office on November 19, 1943:

Five copies of the above information were  
forwarded to the following offices:  
1. Bureau of Investigation  
2. Department of Justice  
3. Federal Bureau of Investigation  
4. Federal Bureau of Investigation  
5. Federal Bureau of Investigation

Very truly yours,  
Special Agent in Charge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  |   |  |  |  |   |  |
|--|--|---|--|---|--|--|--|---|--|
| 1. FOR STATE REGISTRAR   |  | 7 9 3 0 4 5 7<br>REG. NO.   |  |   |  |  |  |   |  |
| 1 DECEASED NAME (TYPE OR PRINT)  |  | FIRST MIDDLE LAST   |  | 2a DATE OF DEATH MONTH DAY YEAR   |  | 2b HOUR  |  |   |  |
| CARLUTHIA  |  | NAPIER  |  | 12 22 79  |  | 17:15  |  | M   |  |
| 3 SEX  |  | 4 RACE  |  | 5 DATE OF BIRTH MONTH DAY YEAR  |  | 6 AGE (IN YEARS LAST BIRTHDAY)   |  | IF UNDER 1 YEAR IF UNDER 24 HRS                                     |  |
| F  |  | BLK.  |  | 11 29 30  |  | 49   |  | MONTHS DAYS HOURS MIN   |  |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  | 7b CITIZEN OF WHAT COUNTRY?   |  | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH  |  |   |  |
| VA   |  | USA   |  |   |  | BALTIMORE MD.  |  |   |  |
| 10 CITY OR TOWN OF DEATH   |  | 11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |   |  | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)   |  | 12b KIND OF BUSINESS OR INDUSTRY                                    |  |
| BALTIMORE  |  | U.S. PUBLIC HEALTH SERVICE HOSPITAL   |  |   |  | HOUSEWIFE  |  |   |  |
| 13a STATE  |  |   |  | 13b COUNTY  |  | 13c CITY OR TOWN   |  | 13d INSIDE CITY LIMITS?   |  |
| MD.  |  |   |  | BALTI.  |  | BALTI.   |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 14 FATHER'S NAME FIRST MIDDLE LAST   |  |   |  | 15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST   |  |  |  |   |  |
| ROBERT   |  |   |  | BURRIE HOWARD   |  |  |  |   |  |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)   |  | 16b SOCIAL SECURITY NO  |  | 17 INFORMANT ADDRESS  |  |  |  |   |  |
| NO   |  | 233 242 124   |  | HOSPITAL RECORD   |  |  |  |   |  |
| 18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c):<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) MASSIVE GI BLEED<br>5715<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) ESOPHAGEAL VARICES ASSOCIATED WITH PORTAL HYPERTENSION<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) CIRRHOSIS OF LIVER |  |   |  |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                        |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |   |  |   |  |  |  |   |  |
| 19a DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |  | 20a AUTOPSY?   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?      |  |
|  |  |   |  |   |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | YES <input type="checkbox"/> NO <input type="checkbox"/>            |  |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR   |  | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |  |  |   |  |
|  |  | P.M. 19   |  |   |  |  |  |   |  |
| 21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |  |  |   |  |
|  |  |   |  |   |  |  |  |   |  |
| 22 I certify that (I) (this hospital) attended the deceased from 12-10 1979, to 12-22 1979, that (I) (we) lost saw the deceased alive on 12-22 1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.      |  |   |  |   |  |  |  |   |  |
| 22b SIGNATURE  |  | DEGREE  |  |   |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c DATE SIGNED   |  |
| Melva J. Brown M.D.  |  |   |  |   |  |  |  | 12/23/79  |  |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT)   |  | 22e ADDRESS   |  |   |  |  |  |   |  |
| Melva J. Brown M.D.  |  | 3100 Wyman Park Drive, BALTI.   |  |   |  |  |  |   |  |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY)   |  | 23b DATE  |  | 23c NAME OF CEMETERY OR CREMATORY   |  | 23d LOCATION CITY OR TOWN COUNTY STATE   |  |   |  |
| Burial   |  | 12/29/79  |  | MT. SINAI   |  | NANSEMOND VA.  |  |   |  |
| 24 FUNERAL DIRECTOR NAME   |  |   |  | ADDRESS   |  | 25a DATE REC'D. BY REGISTRAR   |  | 25b REGISTRAR'S SIGNATURE   |  |
| JAS. A. MORTON & SONS  |  |   |  | 1701 LAURENS  |  | DEC 27 1979  |  | [Signature]   |  |

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

7 9 3 0 4 5 8

|  |  |   |  |
|--|--|---|--|
| FOR<br>STATE<br>REGISTRAR  |  | REG. NO.  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  | 2a. DATE OF DEATH   |  |
| C. Naomi NAU   |  | MONTH DAY YEAR  |  |
| 3. SEX   |  | 4. RACE   |  |
| Female   |  | White   |  |
| 5. DATE OF BIRTH   |  | 6. AGE (IN YEARS LAST BIRTHDAY)   |  |
| MONTH DAY YEAR   |  | 79 YRS  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  | 7b. CITIZEN OF WHAT COUNTRY?  |  |
| Baltimore, Maryland  |  | USA   |  |
| 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH  |  |
|  |  | Baltimore City MD.  |  |
| 10. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |
| Baltimore  |  | North Charles General Hospital  |  |
| 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)   |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |
| retired - housewife  |  | Own Home  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  | 13b. INSIDE CITY LIMITS?  |  |
| 13a. STATE   |  | 13b. YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                  |  |
| Maryland   |  | 13c. CITY OR TOWN   |  |
|  |  | Baltimore   |  |
| 14. FATHER'S NAME  |  | 15. MOTHER'S MAIDEN NAME  |  |
| FIRST MIDDLE LAST  |  | FIRST MIDDLE LAST   |  |
| Jacob P. Apperco   |  | Mary R. Nash  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)   |  | 16b. SOCIAL SECURITY NO.  |  |
| No   |  | 212-24-8854   |  |
| 17. INFORMANT  |  | ADDRESS   |  |
| James J. Nau Sr.   |  | Same  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))   |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH   |  |
| PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a)  |  | CARDIAC ARREST  |  |
| 4439   |  | 5 DAYS  |  |
| DUE TO, OR AS A CONSEQUENCE OF   |  | RENAL FAILURE   |  |
| (b)  |  |   |  |
| DUE TO, OR AS A CONSEQUENCE OF   |  |   |  |
| (c)  |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |   |  |
| DIABETES MELLITUS, ATHEROSCLEROTIC PERIPHERAL VASCULAR DISEASE.  |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |
| 12-3-1979  |  | PERIPHERAL VASCULAR DISEASE   |  |
| 20a. AUTOPSY?  |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?   |  |
| YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | YES <input type="checkbox"/> NO <input type="checkbox"/>  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR   |  |
|  |  | P.M. 19   |  |
| 21d. INJURY OCCURRED   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  |
| WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |
|  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 11-27-1979 to 12-10-1979, that (I) (we) last saw the deceased alive on 12-10-1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death. |  |   |  |
| 22b. SIGNATURE   |  | 22c. DATE SIGNED  |  |
| Vamper Kuruvilla   |  | 12-11-1979  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  | 22e. ADDRESS  |  |
| VARUGHESE KURUVILLA M.D.   |  | NORTH CHARLES HOSPITAL,<br>BALTIMORE, MD. 21218.  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)   |  | 23b. DATE   |  |
| Burial   |  | 12/14/79  |  |
| 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE  |  |
| Druid Ridge  |  | Pikesville, Md.   |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS   |  | 25a. DATE REC'D. BY REGISTRAR   |  |
| Henry W. Jenkins & Sons Co.<br>4905 York Road Balto., Md. 21212  |  | 25b. REGISTRAR'S SIGNATURE  |  |
|  |  | FEB 17 1979   |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

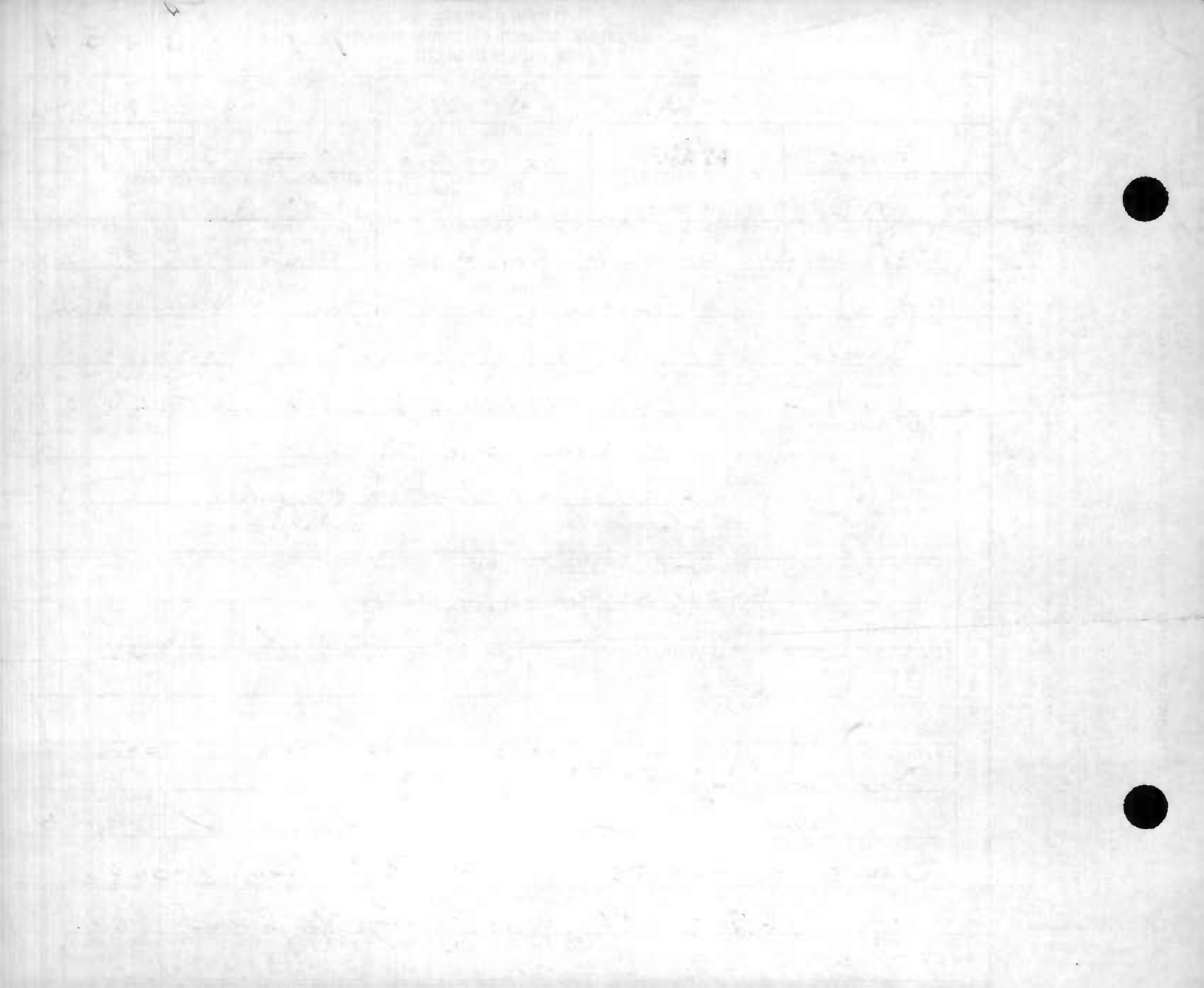




TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  |  |  |  |  |  |  | REG. NO. 7 9 3 0 4 5 9  |  |          |  |
|--|--|---|--|--|--|--|--|--|--|---|--|----------|--|
| 1. FOR STATE REGISTRAR   |  |   |  |  |  |  |  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR  |  | 2b. HOUR |  |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Mary Catherine KRISSE   |  |   |  |  |  |  |  |  |  | 12-04-79  |  | 10:35 AM |  |
| 3. SEX Female  |  | 4. RACE White   |  | 5. DATE OF BIRTH MONTH DAY YEAR 02 07 00   |  | 6. AGE (IN YEARS LAST BIRTHDAY) 79 YRS.  |  | 7. IF UNDER 1 YEAR MONTHS DAYS   |  | 8. IF UNDER 24 HRS. HOURS MIN.  |  |          |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD   |  | 7b. CITIZEN OF WHAT COUNTRY? USA  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTO. CO. MD.                            |  |  |  |   |  |          |  |
| 10. CITY OR TOWN OF DEATH Baltimore  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) So. Balt. Gen. Hosp. |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife        |  | 12b. KIND OF BUSINESS OR INDUSTRY at Home  |  |   |  |          |  |
| 13a. STATE md  |  |   |  | 13b. COUNTY Baltimore  |  | 13c. CITY OR TOWN Baltimore  |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 13e. STREET ADDRESS 1240 Glyndon Ave 21223  |  |          |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST JAMES Kimball  |  |   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST SARAH GEISS   |  |  |  | ADDRESS Glen Burnie, Md. 21061   |  |   |  |          |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No   |  | 16b. SOCIAL SECURITY NO. 21724-7264   |  | 17. INFORMANT David J. Titcher 16 Forestdale Dr.   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                   |  |  |  |   |  |          |  |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cardiogenic Shock<br>410-<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:<br>(b) Acute Atherosclerotic Myocardial Infarction<br>(c) Intentional |  |   |  |  |  |  |  |  |  |   |  |          |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c) Hypertension   |  |   |  |  |  |  |  |  |  |   |  |          |  |
| 19a. DATE OF OPERATION   |  |   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |          |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |  |  |   |  |          |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                 |  |  |  |   |  |          |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 12/3 19 79, to 12/4 19 79, that (I) (we) last saw the deceased alive on 12/4 19 79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.              |  |   |  |  |  |  |  |  |  |   |  |          |  |
| 22b. SIGNATURE David M. Phelps   |  |   |  | DEGREE   |  |  |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED 12/4/79  |  |          |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) DAVID M. PHELPS  |  |   |  | 22e. ADDRESS So. Balt. Gen. Hosp.  |  |  |  |  |  |   |  |          |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial   |  |   |  | 23b. DATE 12-7-79  |  | 23c. NAME OF CEMETERY OR CREMATORY Glen Haven Cemetery                         |  | 23d. LOCATION CITY OR TOWN COUNTY STATE Glen Burnie Md.  |  |   |  |          |  |
| 24. FUNERAL DIRECTOR NAME John E. Brown  |  |   |  | ADDRESS 901 Hollins St.  |  | 25a. DATE REC'D. BY REGISTRAR DEC 5 1979                                       |  | 25b. REGISTRAR'S SIGNATURE [Signature]   |  |   |  |          |  |



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, RELEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR OR PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 48 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

## MEDICAL CERTIFICATION

| 1. FOR STATE REGISTRAR  |  |         |  |                  |   |                   |  |                   |  | DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH |  |                         |  |                          |  |                         |  |          |  | REG. NO. 30460             |  |  |  |  |  |  |  |  |  |
|---|--|---------|--|------------------|---|-------------------|--|-------------------|--|--|--|-------------------------|--|--------------------------|--|-------------------------|--|----------|--|----------------------------|--|--|--|--|--|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |  |         |  |                  | FIRST MIDDLE LAST   |                   |  |                   |  | 2a. DATE OF DEATH  |  |                         |  |                          | 2b. HOUR                                     |                         |  |          |  |                            |  |  |  |  |  |  |  |  |  |
| Dempsy  |  |         |  |                  | Colombus  |                   |  |                   |  | Newby  |  |                         |  |                          | 12 2 19 79                                   |                         |  |          |  | M                          |  |  |  |  |  |  |  |  |  |
| 3. SEX  |  | 4. RACE |  | 5. DATE OF BIRTH |   | 6. AGE (IN YEARS) |  | 7. IF UNDER 1 YR. |  | 8. IF UNDER 24 HRS.  |  | 9. DATE PRONOUNCED DEAD |  | 10. HOUR                 |  | 11. DATE                |  | 12. HOUR |  |                            |  |  |  |  |  |  |  |  |  |
| Male  |  | Black   |  | 9 4 1908         |   | 71 YRS.           |  | MONTHS DAYS       |  | HOURS MIN  |  | 12 3 19 79              |  | 2:43 P M                 |  |                         |  |          |  |                            |  |  |  |  |  |  |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  |         |  |                  | 7b. CITIZEN OF WHAT COUNTRY?                                |                   |  |                   |  | 8. MARRIED   |  |                         |  |                          | 9. BALTIMORE CITY OR COUNTY OF DEATH         |                         |  |          |  |                            |  |  |  |  |  |  |  |  |  |
| Virginia  |  |         |  |                  | U. S. A.  |                   |  |                   |  | WIDOWED NEVER MARRIED DIVORCED   |  |                         |  |                          | Baltimore City, MD                           |                         |  |          |  |                            |  |  |  |  |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH   |  |         |  |                  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION    |                   |  |                   |  | 12a. USUAL OCCUPATION (TYPE OF WORK)   |  |                         |  |                          | 12b. KIND OF BUSINESS OR INDUSTRY            |                         |  |          |  |                            |  |  |  |  |  |  |  |  |  |
| Baltimore   |  |         |  |                  | 2320 E. Biddle Street                                       |                   |  |                   |  |  |  |                         |  |                          |  |                         |  |          |  |                            |  |  |  |  |  |  |  |  |  |
| 13a. STATE  |  |         |  |                  |   |                   |  |                   |  | 13b. COUNTY  |  | 13c. CITY OR TOWN       |  | 13d. INSIDE CITY LIMITS? |  | 13e. STREET ADDRESS     |  |          |  |                            |  |  |  |  |  |  |  |  |  |
| Maryland  |  |         |  |                  |   |                   |  |                   |  |  |  | Baltimore               |  | YES X NO                 |  | 2320 East Biddle Street |  |          |  |                            |  |  |  |  |  |  |  |  |  |
| 14. FATHER'S NAME   |  |         |  |                  | 15. MOTHER'S MAIDEN NAME                                    |                   |  |                   |  |  |  |                         |  |                          |  |                         |  |          |  |                            |  |  |  |  |  |  |  |  |  |
| Eugene  |  |         |  |                  | Newby   |                   |  |                   |  | Julia Ann Kelly  |  |                         |  |                          |  |                         |  |          |  |                            |  |  |  |  |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?  |  |         |  |                  | 16b. SOCIAL SECURITY NO.                                    |                   |  |                   |  | 17. INFORMANT ADDRESS  |  |                         |  |                          |  |                         |  |          |  |                            |  |  |  |  |  |  |  |  |  |
| No  |  |         |  |                  | 213-07-0715   |                   |  |                   |  | Columbus Newby 1211 North Decker Avenue  |  |                         |  |                          |  |                         |  |          |  |                            |  |  |  |  |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |  |         |  |                  |   |                   |  |                   |  |  |  |                         |  |                          | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |                         |  |          |  |                            |  |  |  |  |  |  |  |  |  |
| PART I DEATH WAS CAUSED BY: Arteriosclerotic Cardiovascular Disease   |  |         |  |                  |   |                   |  |                   |  |  |  |                         |  |                          |  |                         |  |          |  |                            |  |  |  |  |  |  |  |  |  |
| IMMEDIATE CAUSE (a)   |  |         |  |                  |   |                   |  |                   |  |  |  |                         |  |                          |  |                         |  |          |  |                            |  |  |  |  |  |  |  |  |  |
| 4292 } DUE TO, OR AS A CONSEQUENCE OF   |  |         |  |                  |   |                   |  |                   |  |  |  |                         |  |                          |  |                         |  |          |  |                            |  |  |  |  |  |  |  |  |  |
| Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.   |  |         |  |                  |   |                   |  |                   |  |  |  |                         |  |                          |  |                         |  |          |  |                            |  |  |  |  |  |  |  |  |  |
| (b)   |  |         |  |                  |   |                   |  |                   |  |  |  |                         |  |                          |  |                         |  |          |  |                            |  |  |  |  |  |  |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF  |  |         |  |                  |   |                   |  |                   |  |  |  |                         |  |                          |  |                         |  |          |  |                            |  |  |  |  |  |  |  |  |  |
| (c)   |  |         |  |                  |   |                   |  |                   |  |  |  |                         |  |                          |  |                         |  |          |  |                            |  |  |  |  |  |  |  |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a):   |  |         |  |                  |   |                   |  |                   |  |  |  |                         |  |                          |  |                         |  |          |  |                            |  |  |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION  |  |         |  |                  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?           |                   |  |                   |  |  |  |                         |  |                          |  |                         |  |          |  | 20. AUTOPSY?               |  |  |  |  |  |  |  |  |  |
|   |  |         |  |                  |   |                   |  |                   |  |  |  |                         |  |                          |  |                         |  |          |  | YES NO X                   |  |  |  |  |  |  |  |  |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH   |  |         |  |                  | 21b. TIME OF INJURY   |                   |  |                   |  | 21c. HOW INJURY OCCURRED   |  |                         |  |                          |  |                         |  |          |  |                            |  |  |  |  |  |  |  |  |  |
|   |  |         |  |                  | HOUR A.M. MONTH DAY YEAR                                    |                   |  |                   |  | ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2                                 |  |                         |  |                          |  |                         |  |          |  |                            |  |  |  |  |  |  |  |  |  |
|   |  |         |  |                  | P.M. 19   |                   |  |                   |  |  |  |                         |  |                          |  |                         |  |          |  |                            |  |  |  |  |  |  |  |  |  |
| 21d. INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK  |  |         |  |                  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) |                   |  |                   |  | 21f. LOCATION  |  |                         |  |                          |  |                         |  |          |  |                            |  |  |  |  |  |  |  |  |  |
|   |  |         |  |                  |   |                   |  |                   |  | STREET CITY OR TOWN COUNTY STATE   |  |                         |  |                          |  |                         |  |          |  |                            |  |  |  |  |  |  |  |  |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy Inspection Inquiry, and in my opinion death resulted from: Natural causes Accident Suicide Homicide Undetermined manner |  |         |  |                  |   |                   |  |                   |  |  |  |                         |  |                          |  |                         |  |          |  |                            |  |  |  |  |  |  |  |  |  |
| Actual Signature Virginia L. Dolan M.D. TITLE (SPECIFY) Assistant MEDICAL EXAMINER DATE SIGNED 12/4/79  |  |         |  |                  |   |                   |  |                   |  |  |  |                         |  |                          |  |                         |  |          |  |                            |  |  |  |  |  |  |  |  |  |
| EXAMINER'S NAME (TYPE OR PRINT) Virginia L. Dolan, M.D. ADDRESS 111 Penn Street   |  |         |  |                  |   |                   |  |                   |  |  |  |                         |  |                          |  |                         |  |          |  |                            |  |  |  |  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   |  |         |  |                  | 23b. DATE   |                   |  |                   |  | 23c. NAME OF CEMETERY OR CREMATORY   |  |                         |  |                          | 23d. LOCATION                                |                         |  |          |  |                            |  |  |  |  |  |  |  |  |  |
| Burial  |  |         |  |                  | 12/8/1979   |                   |  |                   |  | Baltimore Cemetery   |  |                         |  |                          | Baltimore, Maryland                          |                         |  |          |  |                            |  |  |  |  |  |  |  |  |  |
| 24. FUNERAL DIRECTOR  |  |         |  |                  |   |                   |  |                   |  | 25a. DATE REC'D. BY REGISTRAR  |  |                         |  |                          |  |                         |  |          |  | 25b. REGISTRAR'S SIGNATURE |  |  |  |  |  |  |  |  |  |
| NAME ADDRESS  |  |         |  |                  |   |                   |  |                   |  | DEC 5 1979   |  |                         |  |                          |  |                         |  |          |  |                            |  |  |  |  |  |  |  |  |  |
| Wm. C. March F/H 1101 East North Avenue   |  |         |  |                  |   |                   |  |                   |  |  |  |                         |  |                          |  |                         |  |          |  |                            |  |  |  |  |  |  |  |  |  |

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

7 9 3 0 4 6 1

1 - FOR  
STATE  
REGISTRAR

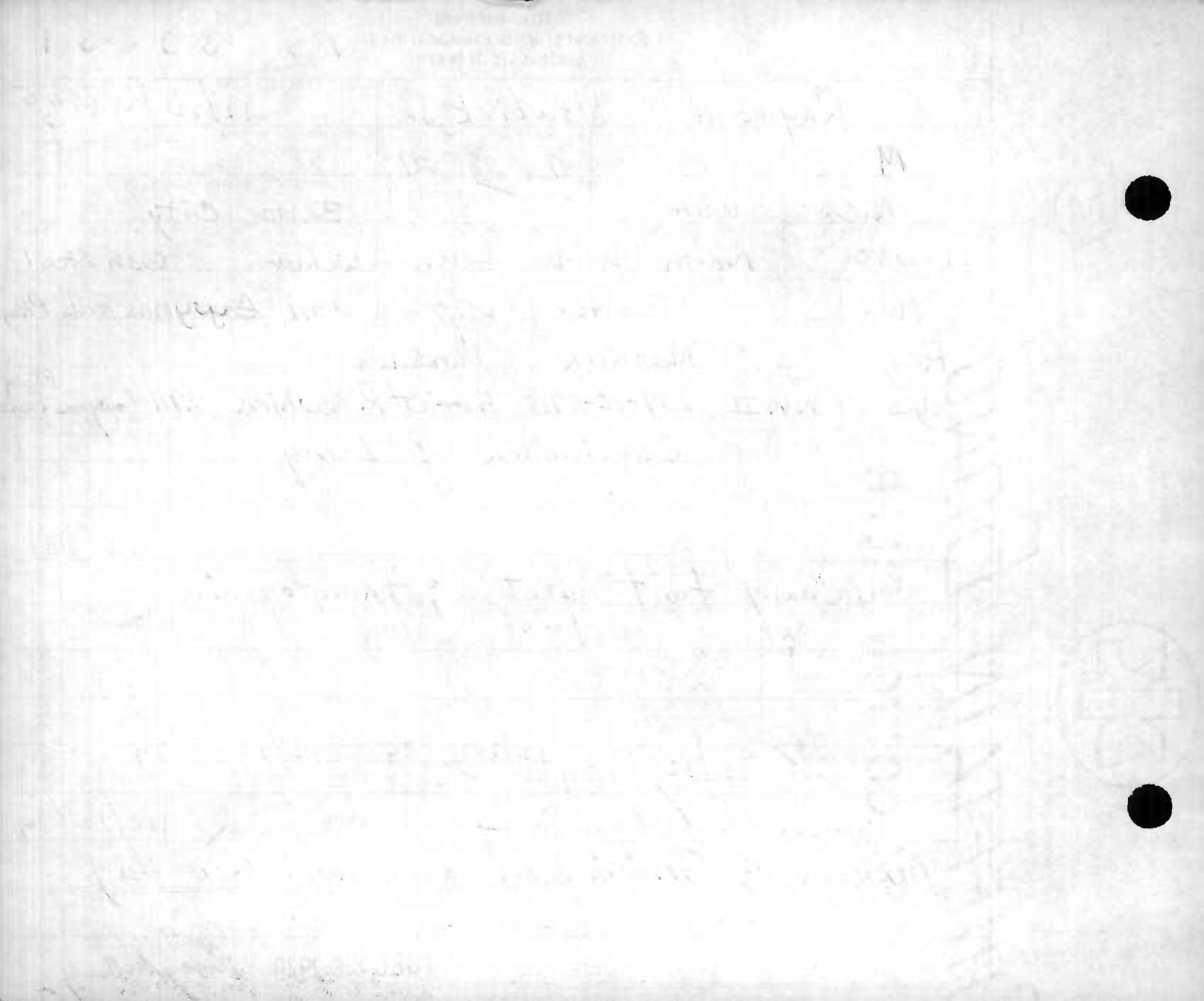
REG. NO.

|   |  |  |  |   |                                |   |  |
|---|--|--|--|---|--------------------------------|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><i>Raymond Newkirk, Jr.</i>   |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><i>12/22/79</i> |   | 2b. HOUR<br>MIN<br><i>6:45</i> |   |  |
| 3. SEX<br><i>M</i>  |  | 4. RACE<br><i>B</i>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><i>7 28 21</i>  |                                | 6. AGE (IN YEARS LAST BIRTHDAY)<br>YRS. MONTHS DAYS HOURS MIN.<br><i>58</i>   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><i>N.C.</i>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><i>USA</i>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><i>Balto. City</i> MD.  |  |
| 10. CITY OR TOWN OF DEATH<br><i>Balto.</i>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><i>North Charles Gen.</i> |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><i>Welder</i>   |                                | 12b. KIND OF BUSINESS OR INDUSTRY<br><i>Beth Steel</i>  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |                                | 13e. STREET ADDRESS<br><i>2911 Gwynnys Falls Pkwy</i>   |  |
| 13a. STATE<br><i>Md.</i>  |  | 13b. COUNTY<br><i>Balto.</i>   |  | 13c. CITY OR TOWN<br><i>Balto.</i>  |                                | 13f. STREET ADDRESS<br><i>2911 Gwynnys Falls Pkwy</i>   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><i>Ray Newkirk</i>  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><i>Vandalia</i>   |  | 16. ADDRESS<br><i>2911 Gwynnys Falls Pkwy</i>   |                                | 17. INFORMANT<br><i>Harriet R. Newkirk</i>  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><i>YES</i>  |  | 16b. SOCIAL SECURITY NO.<br><i>237-20-5788</i>   |  | 16c. DATE OF DEATH<br><i>12/22/79</i>   |                                | 16d. DATE OF DEATH<br><i>12/22/79</i>   |  |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Carcinoma of Lung</i><br>DUE TO, OR AS A CONSEQUENCE OF (b) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) _____<br>DUE TO, OR AS A CONSEQUENCE OF (c) _____ |  |  |  |   |                                |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><i>Urinary tract infection; pancytopenia</i>  |  |  |  |   |                                |   |  |
| 19a. DATE OF OPERATION<br><i>12/22/79</i>   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><i>Urinary tract infection; pancytopenia</i>                                       |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                                | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><i>12/22/79</i>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |                                | 21d. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br><i>North Charles Gen. Hosp.</i>  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br><i>North Charles Gen. Hosp.</i>  |                                | 21g. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br><i>North Charles Gen. Hosp.</i>  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>12/22/79</i> to <i>12/22/79</i> , that (I) (we) lost saw the deceased alive on <i>12/22/79</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (do) (did not) view the body after death.                              |  |  |  |   |                                |   |  |
| 22b. SIGNATURE<br><i>Marcos B. Galicia Jr., MD</i>  |  | 22c. DEGREE<br><i>MD</i>   |  | 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><i>MARCO B. GALICIA JR. MD</i>   |                                | 22e. ADDRESS<br><i>North Charles Gen. Hosp.</i>   |  |
| 22f. PHYSICIAN'S NAME (TYPE OR PRINT)<br><i>MARCO B. GALICIA JR. MD</i>   |  | 22g. ADDRESS<br><i>North Charles Gen. Hosp.</i>  |  | 22h. ADDRESS<br><i>North Charles Gen. Hosp.</i>   |                                | 22i. ADDRESS<br><i>North Charles Gen. Hosp.</i>   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><i>Burial</i>   |  | 23b. DATE<br><i>12/26/79</i>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><i>Cedar Hill Cem.</i>  |                                | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><i>Anne Arundel Co., Md.</i>  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><i>Wm C March F/H</i>   |  | 24b. ADDRESS<br><i>1101 E. North Ave.</i>  |  | 25a. DATE REC'D. BY REGISTRAR<br><i>DEC 26 1979</i>   |                                | 25b. REGISTRAR'S SIGNATURE<br><i>Robert H. Brady</i>  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon-papers. Pages 1 and 2 should be filed with the health officer after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



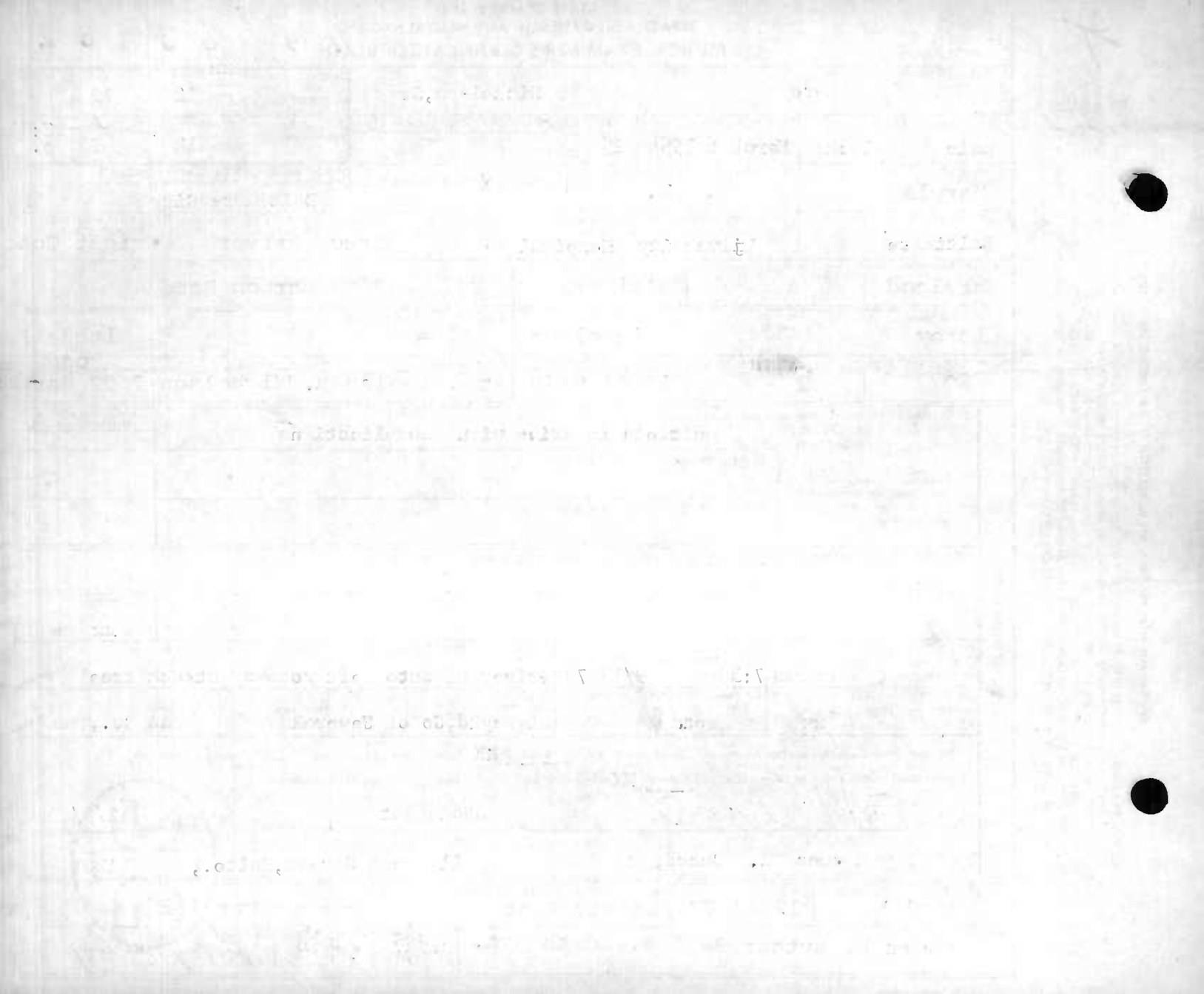
TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 5. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED. WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND. 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DHM-17  
(VR A15 ME (5))  
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| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |  |             |  |                                    |   |   |   |  |   | REG. NO. 30462                |  |
|--|--|-------------|--|------------------------------------|---|---|---|--|---|-------------------------------|--|
| 1. FOR STATE REGISTRAR   |  |             |  |                                    |   |   |   |  |   |                               |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  |             | FIRST  |                                    | MIDDLE  |   | LAST  |  | 2a. DATE KNOWN OF DEATH   |                               |  |
| Leroy  |  |             |  |                                    |   |   | Nicholson, Jr   |  | ESTIMATED <input type="checkbox"/> 12 5 19 79                                       |                               |  |
| 3. SEX   |  | 4. RACE     |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR |   | 6. AGE (IN YEARS)<br>(LAST BIRTHDAY)  |   | IF UNDER 1 YR.<br>MONTHS DAYS              |   | IF UNDER 24 HRS.<br>HOURS MIN |  |
| male   |  | black       |  | March 6 1954                       |   | 25 YRS.   |   |  |   |                               |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  |             | 7b. CITIZEN OF WHAT COUNTRY?   |                                    |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH       |   |                               |  |
| Maryland   |  |             | U.S.A.   |                                    |   |   |   | Baltimore City MD.                         |   |                               |  |
| 10. CITY OR TOWN OF DEATH  |  |             | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |                                    |   |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) |  | 12b. KIND OF BUSINESS OR INDUSTRY   |                               |  |
| Baltimore  |  |             | University Hospital  |                                    |   |   | Truck Driver  |  | Wright Con.   |                               |  |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |             |  |                                    |   |   |   |  |   |                               |  |
| 13a. STATE   |  | 13b. COUNTY |  | 13c. CITY OR TOWN                  |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |   | 13e. STREET ADDRESS                        |   |                               |  |
| Maryland   |  |             |  | Baltimore                          |   |   |   | 7609 Harmon Road                           |   |                               |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST   |  |             |  |                                    | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST                                 |   |   |  |   |                               |  |
| Leroy Nicholson  |  |             |  |                                    | Alma Mitchell   |   |   |  |   |                               |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)  |  |             |  |                                    | 16b. SOCIAL SECURITY NO.  |   | 17. INFORMANT ADDRESS   |  |   |                               |  |
| NO   |  |             |  |                                    | 217-62-9848   |   | Mrs. Denise R. Nicholson 7609 Harmon Road                     |  |   |                               |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Multiple injuries with complications<br>8150<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b) DUE TO, OR AS A CONSEQUENCE OF<br>(c) DUE TO, OR AS A CONSEQUENCE OF<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                              |  |             |  |                                    |   |   |   |  |   |                               |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).  |  |             |  |                                    |   |   |   |  |   |                               |  |
| 19a. DATE OF OPERATION   |  |             | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |                                    |   |   |   |  | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                               |  |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |  |             | 21b. TIME OF INJURY<br>HOUR AM MONTH DAY YEAR  |                                    | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) |   |   |  |   |                               |  |
|  |  |             | 7:30 P.M. 9/17/79  |                                    | driver of auto left roadway struck tree                                       |   |   |  |   |                               |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>   |  |             | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)  |                                    | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                             |   |   |  |   |                               |  |
|  |  |             | road   |                                    | Disney Rd, So of Severn Rd.   |   | AA Co., MD  |  |   |                               |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |  |             |  |                                    |   |   |   |  |   |                               |  |
| ACTUAL SIGNATURE <i>H. R. Guard</i>  |  |             |  |                                    | TITLE (SPECIFY) Assistant   |   | MEDICAL EXAMINER  |  | DATE SIGNED 12/5/79   |                               |  |
| EXAMINER'S NAME (TYPE OR PRINT) Hormez R. Guard, MD  |  |             |  |                                    | ADDRESS 111 Penn Street, Balto., MD 21201                                     |   |   |  |   |                               |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |  |             | 23b. DATE  |                                    | 23c. NAME OF CEMETERY OR CREMATORY  |   |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE |   |                               |  |
| Burial   |  |             | 12-11-79   |                                    | Saints Rest Cem;  |   |   | Hanover Maryland                           |   |                               |  |
| 24. FUNERAL DIRECTOR<br>Herbert E. Nutter ADDRESS 3035 W. North Ave.   |  |             |  |                                    | 25a. DATE REC'D. BY REGISTRAR DEC 7 1979                                      |   | 25b. REGISTRAR'S SIGNATURE <i>John H. Brady</i>               |  |   |                               |  |

MEDICAL CERTIFICATION







TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of cause.

MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  | 7 9 3 0 4 6 3<br>REG. NO.  |  |  |  |
|--|--|---|--|--|--|--|--|
| 1. FOR STATE REGISTRAR   |  |   |  | 2a. DATE OF DEATH  |  |  |  |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br><b>WILMA J.ane NIEBRUGGE</b>   |  |   |  | MONTH DAY YEAR<br><b>12 23 79</b>  |  | 2b. HOUR<br><b>5.15 P.M.</b>   |  |
| 3. SEX<br><b>Female</b>  |  | 4. RACE<br><b>C White</b>   |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>1 28 / 21</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>58</b>   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MARYLAND</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.  |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>UNIVERSITY OF MD. HOSPITAL</b> |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Tele. Oper.</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Physician Exchange</b>   |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>M.D.</b>   |  |   |  | 13b. COUNTY<br><b>BALTIMORE</b>  |  | 13c. CITY OR TOWN<br><b>BALTIMORE</b>  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>ROBERT Daniel MERRYMAN</b>   |  |   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE<br><b>Abel ABEL</b>  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br><b>NO</b>   |  |   |  | 16b. SOCIAL SECURITY NO.<br><b>NOT KNOWN</b>   |  | 17. INFORMANT ADDRESS<br><b>SISTER Mildred E. Barbee--As in 13e</b>  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CEREBRAL METASTASIS OF CA LUNG</b><br>1629<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(b) <b>SMALL CELL CA LUNG</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>SMALL CELL CA LUNG</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>6 WEEKS.</b><br><b>6 WEEKS.</b> |  |   |  |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><b>ACUTE MYOCARDIAL INFARCTION</b>  |  |   |  |  |  |  |  |
| 19a. DATE OF OPERATION<br><b>12/6/79</b>   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>CEREBRAL METASTASIS OF CA LUNG</b>   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |  |  |
| 22a. I certify that (this hospital) attended the deceased from <b>12/6</b> , 19 <b>79</b> , to <b>12/23</b> , 19 <b>79</b> , that (we) last saw the deceased alive on <b>12/23</b> , 19 <b>79</b> , and that in (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) view the body after death.  |  |   |  |  |  |  |  |
| 22b. SIGNATURE<br><b>J. F. Bishop</b>  |  |   |  | DEGREE<br><b>M.D. (Anatomist)</b>  |  | 22c. DATE SIGNED<br><b>12/23</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>J. F. BISHOP</b>   |  |   |  | 22e. ADDRESS<br><b>% BCRP U.M.H. 22 S GREEN ST BALTO MD.</b>   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Cremation</b>  |  | 23b. DATE<br><b>12/26/1979</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Green Mount</b>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Md.</b>   |  |
| 24. FUNERAL DIRECTOR NAME<br><b>Walter Brooks Bradley Inc. Dundalk Md.</b>   |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>DEC 28 1979</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>Robert McCreedy</b>   |  |

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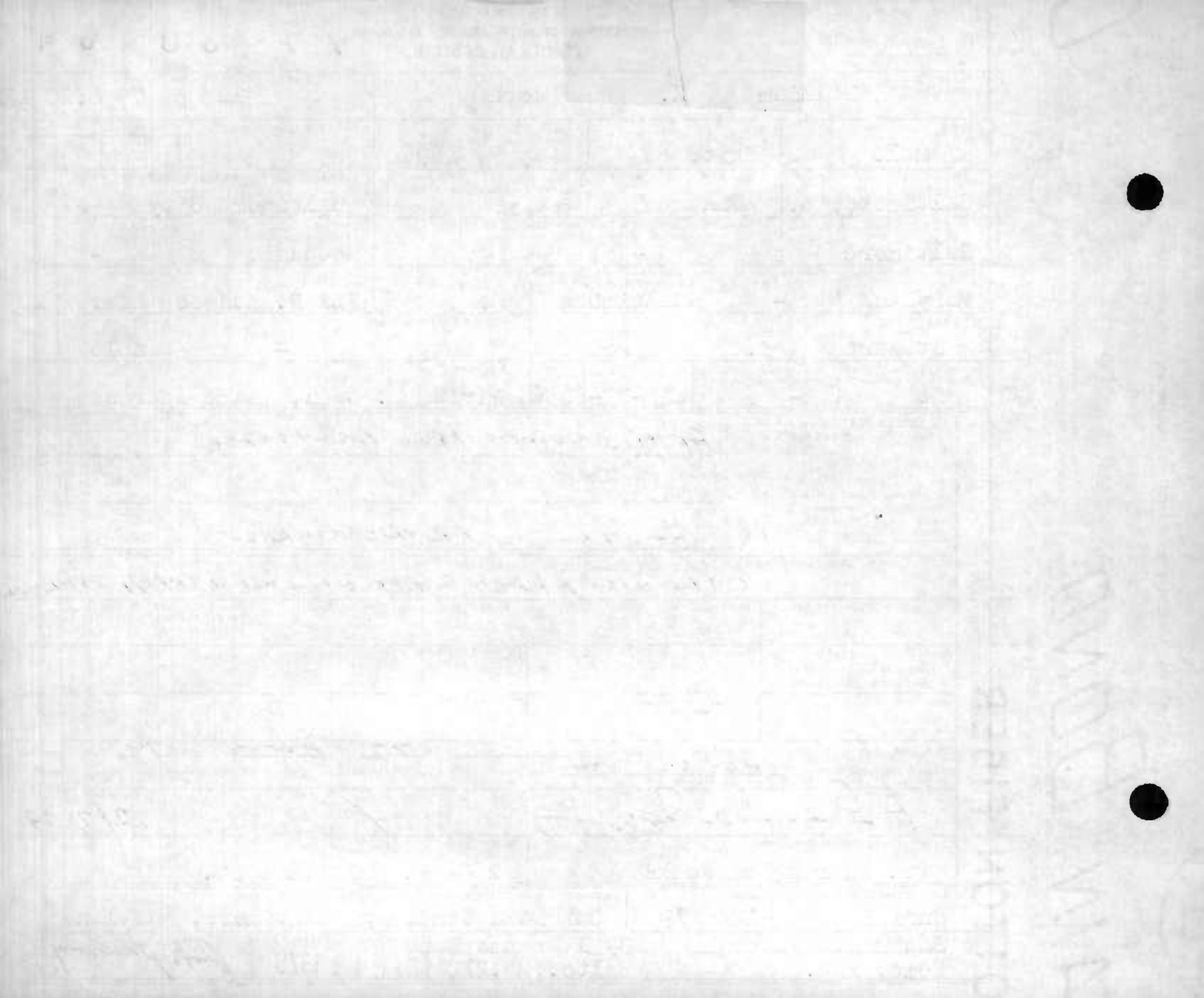
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by this funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified by telephone.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  |  |  |  |  |  |  |
|---|--|---|--|--|--|--|--|--|--|
| 1. FOR STATE REGISTRAR  |  | 7 9 3 0 4 6 4   |  |  |  | REG. NO.   |  |  |  |
| 1. DECEASED NAME (TYPE OR PRINT)  |  | FIRST MIDDLE LAST<br>William H. Nixon   |  |  |  | 2b. DATE OF DEATH MONTH DAY YEAR<br>12 5 79  |  | 2b. HOUR AM PM<br>8:20 AM                                  |  |
| 3 SEX<br>Male   |  | 4 RACE<br>White   |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>May 7, 1896   |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br>83   |  | IF UNDER 1 YEAR MONTHS DAYS<br>IF UNDER 24 HRS. HOURS MIN. |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Baltimore, Md.   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.  |  |  |  |
| 10 CITY OR TOWN OF DEATH<br>Baltimore   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>- |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Mechanic  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>-                     |  |
| 13a. STATE<br>Maryland  |  | 13b. COUNTY<br>-  |  | 13c. CITY OR TOWN<br>Baltimore   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 13e. STREET ADDRESS<br>721 N. Kenwood Ave. 21205           |  |
| 14 FATHER'S NAME FIRST MIDDLE LAST<br>Stewart D. Nixon  |  | 15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Lucy - Able  |  |  |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>No   |  | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)<br>-   |  | 17 INFORMANT ADDRESS<br>Miriam F. Cain, same address   |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE 1a. <u>4292</u> <u>Arteriosclerotic Cardio-Vasc. Disease</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>1b. <u>Generalized Arteriosclerosis</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>1c. <u>Chronic Brain Syndrome - due to Cerebr. Arteriosclerosis</u> |  |   |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH               |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 1d.<br><u>Chronic Brain Syndrome - due to Cerebr. Arteriosclerosis</u>   |  |   |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                 |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |  |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 19 <u>72</u> to <u>Dec 5</u> 19 <u>79</u> , that (I) (we) last saw the deceased alive on <u>Nov 30</u> 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (and) (did not) view the body after death.                           |  |   |  |  |  |  |  |  |  |
| 22b. SIGNATURE <u>Dr. Andrew Lemischka</u>  |  |   |  | DEGREE   |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED <u>12/7/79</u>                            |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Dr. Andrew Lemischka   |  |   |  | 22e. ADDRESS<br>2608 E. Baltimore St.  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial   |  | 23b. DATE<br>12/8/79  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Oak Lawn Cemetery  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br>Baltimore, Maryland   |  |  |  |
| 24. FUNERAL DIRECTOR<br>Schimunek Funeral Home, Inc.  |  | ADDRESS<br>3331 Brehms Lane<br>Balto., Md. 21211  |  | 25a. DATE REC'D. BY REGISTRAR<br>DEC 11 1979   |  | 25b. REGISTRAR'S SIGNATURE<br><u>Jeffrey McReady</u>   |  |  |  |



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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| FOR<br>1- STATE<br>REGISTRAR  |  |                         |  |   |  |   |  |   |  | STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH |  |   |  |   |  |  |  |  |  | REG. NO. 9 30465                   |  |                                       |  |
|---|--|-------------------------|--|---|--|---|--|---|--|---|--|---|--|---|--|--|--|--|--|------------------------------------|--|---------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>Maude Norris</b>   |  |                         |  |   |  |   |  |   |  | 2a. DATE KNOWN OF DEATH<br>ESTIMATED<br>MONTH DAY YEAR<br><b>12 11 79</b>                               |  |   |  |   |  |  |  |  |  | 2b. HOUR<br>M<br><b>12:17 P.M.</b> |  |                                       |  |
| 3. SEX<br><b>Female</b>   |  | 4. RACE<br><b>Black</b> |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>10 5 1912</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>67</b> YRS. |  | IF UNDER 1 YR.<br>MONTHS DAYS<br><b>12 11</b>   |  | IF UNDER 24 HRS.<br>HOURS MIN.<br><b>19 79</b>  |  | 2c. DATE PRONOUNCED DEAD<br>MONTH DAY YEAR<br><b>12 11 79</b>                       |  |   |  |  |  |  |  |                                    |  | 2d. HOUR<br>P.M.<br><b>12:17 P.M.</b> |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Virginia</b>  |  |                         |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U. S. A.</b>   |  |   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |   |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City,</b> MD.                  |  |   |  |  |  |  |  |                                    |  |                                       |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   |  |                         |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>1925 Etting Street</b> |  |   |  |   |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                       |  |   |  | 12b. KIND OF BUSINESS OR INDUSTRY                |  |  |  |                                    |  |                                       |  |
| 13a. STATE<br><b>Maryland</b>   |  |                         |  |   |  |   |  |   |  | 13b. COUNTY<br><b>Baltimore</b>   |  | 13c. CITY OR TOWN<br><b>Baltimore</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>1925 Etting Street</b> |  |  |  |                                    |  |                                       |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>William Wilson</b>   |  |                         |  |   |  |   |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Julia</b>   |  |   |  |   |  |  |  |  |  |                                    |  |                                       |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)   |  |                         |  | 16b. SOCIAL SECURITY NO.<br><b>219-28-5135</b>  |  |   |  | 17. INFORMANT ADDRESS<br><b>Roger Norris 1925 Etting Street</b>   |  |   |  |   |  |   |  |  |  |  |  |                                    |  |                                       |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Hypertensive Cardiovascular Disease</b><br>4029<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b) _____<br>(c) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>DUE TO, OR AS A CONSEQUENCE OF<br>DUE TO, OR AS A CONSEQUENCE OF   |  |                         |  |   |  |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |   |  |   |  |  |  |  |  |                                    |  |                                       |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).   |  |                         |  |   |  |   |  |   |  |   |  |   |  |   |  |  |  |  |  |                                    |  |                                       |  |
| 19a. DATE OF OPERATION  |  |                         |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |  |   |  |   |  |   |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |   |  |  |  |  |  |                                    |  |                                       |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |  |                         |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)   |  |   |  |   |  |   |  |  |  |  |  |                                    |  |                                       |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK   |  |                         |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)   |  |   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |   |  |   |  |  |  |  |  |                                    |  |                                       |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . |  |                         |  |   |  |   |  |   |  |   |  |   |  |   |  |  |  |  |  |                                    |  |                                       |  |
| ACTUAL SIGNATURE<br><i>Virginia L. Dolan</i>  |  |                         |  | TITLE (SPECIFY)<br><b>Assistant</b>   |  |   |  | MEDICAL EXAMINER  |  |   |  | DATE SIGNED<br><b>12/11/79</b>  |  |   |  |  |  |  |  |                                    |  |                                       |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT)<br><b>Virginia L. Dolan, M.D.</b>  |  |                         |  | ADDRESS<br><b>111 Penn Street</b>   |  |   |  |   |  |   |  |   |  |   |  |  |  |  |  |                                    |  |                                       |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   |  |                         |  | 23b. DATE<br><b>12/15/1979</b>  |  |   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Church Cemetery</b>  |  |   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Wicamcio Church, Virginia</b>      |  |   |  |  |  |  |  |                                    |  |                                       |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Wm. C. March F/H</b>   |  |                         |  | ADDRESS<br><b>1101 East North Avenue</b>  |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>DEC 17 1979</b>   |  |   |  | 25b. REGISTRAR'S SIGNATURE<br><i>History/Calhoun</i>                                |  |   |  |  |  |  |  |                                    |  |                                       |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |   |  |  |  |  |  |   | 7 9 3 0 4 6 6 |  |
|---|--|--|---|--|--|--|--|--|---|---------------|--|
| 1. FOR STATE REGISTRAR  |  |  | REG. NO.  |  |  |  |  |  |   |               |  |
| 1. DECEASED NAME (TYPE OR PRINT)  |  |  | FIRST HARRY MIDDLE L. LAST NUNNALLY   |  |  | 2a. DATE OF DEATH MONTH DAY YEAR   |  |  | 2b. HOUR  |               |  |
| 3. SEX M  |  |  | 4. RACE W   |  |  | 5. DATE OF BIRTH MONTH DAY YEAR 7 09 06  |  |  | 6. AGE (IN YEARS LAST BIRTHDAY) 73 YRS  |               |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND  |  |  | 7b. CITIZEN OF WHAT COUNTRY? U.S.A.   |  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD  |               |  |
| 10. CITY OR TOWN OF DEATH Baltimore   |  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) St. Agnes Hospital   |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) PAPER CUTTER   |  |  | 12b. KIND OF BUSINESS OR INDUSTRY   |               |  |
| 13a. STATE Md.  |  |  | 13b. COUNTY BALTIMORE   |  |  | 13c. CITY OR TOWN ARBUTUS  |  |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |               |  |
| 14. FATHER'S NAME FIRST HARRY MIDDLE L. LAST NUNNALLY   |  |  | 15. MOTHER'S MAIDEN NAME FIRST IVY MIDDLE MAY LAST ZEPP   |  |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO   |  |  | 16b. SOCIAL SECURITY NO. 705-05-6718  |               |  |
| 17. INFORMANT ADDRESS BERTHA M. NUNNALLY 4007 WILKENS AVENUE  |  |  | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart arrest - massive myocardial infarction. (b) Chronic senile angina. (c) Chronic syndrome - Gastroenteritis. Flu. |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |  |   |               |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)   |  |  |   |  |  |  |  |  |   |               |  |
| 19a. DATE OF OPERATION  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>   |  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |               |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19  |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)   |  |  |   |               |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |  |   |               |  |
| 22a. I certify that (I) (this hospital) attended the deceased from Dec. 30, 1979, to Dec. 31, 1979, that (I) (we) lost saw the deceased alive on Dec 30, 1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |   |  |  |  |  |  |   |               |  |
| 22b. SIGNATURE Stanley Ankudovs   |  |  | DEGREE M.D.   |  |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>               |  |  | 22c. DATE SIGNED 12.31.79   |               |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) STANLEY ANKUDOVAS   |  |  | 22e. ADDRESS 1101 Maiden Choice La, Beltsville 21224  |  |  |  |  |  |   |               |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL  |  |  | 23b. DATE 01-03-80  |  |  | 23c. NAME OF CEMETERY OR CREMATORY LOUDON PARK   |  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE CITY MARYLAND   |               |  |
| 24. FUNERAL DIRECTOR NAME HUBBARD FUNERAL HOME, INC.  |  |  | ADDRESS 4107 WILKENS AVE.   |  |  | 25a. DATE REC'D. BY REGISTRAR 1/1/80   |  |  | 25b. REGISTRAR'S SIGNATURE [Signature]  |               |  |

BP

DHMH-16 25M  
(VRA 15, 4) 1/79







TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  |   |  |   |  |   |  |   |  |
|--|--|---|--|---|--|---|--|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  | FIRST   |  | MIDDLE  |  | LAST  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR   |  | 2b. HOUR  |  |
| William J O'Bryan  |  | William J   |  | O'Bryan   |  |   |  | DEC 7 79  |  | 2:45 AM   |  |
| 3. SEX   |  | 4. RACE   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR  |  | 6. AGE (IN YEARS LAST BIRTHDAY)   |  | 7. UNDER 1 YEAR<br>MONTHS DAYS  |  | 8. UNDER 24 HRS<br>HOURS MIN                    |  |
| Male   |  | White   |  | 7 22 01   |  | 78 YRS.   |  |   |  |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  | 7b. CITIZEN OF WHAT COUNTRY?  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH  |  |   |  |   |  |
| Maryland   |  | U.S.A.  |  |   |  | BALTIMORE CITY MD.  |  |   |  |   |  |
| 10. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)  |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |   |  |   |  |
| BALTIMORE  |  | ST. AGNES HOSPITAL  |  | carpenter   |  | railroad  |  |   |  |   |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE   |  | 13b. COUNTY   |  | 13c. CITY OR TOWN   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS   |  |   |  |
| Maryland   |  | Howard  |  | Elkridge  |  | YES   |  | 5682 Railroad Avenue  |  |   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST   |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST   |  |   |  |   |  |   |  |
| Walter O'Bryan   |  |   |  | Alice Harget  |  |   |  |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)   |  |   |  | 16b. SOCIAL SECURITY NO   |  | 17. INFORMANT ADDRESS   |  |   |  |   |  |
| no   |  |   |  | none  |  | Roberta M. O'Bryan 5682 Railroad Avenue   |  |   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <u>Cardio Respiratory arrest</u><br>410 -<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Myocardial Infarction</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>Systolic - Reticus</u>   |  |   |  |   |  |   |  |   |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |   |  |   |  |   |  |   |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |   |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  | 21f. LOCATION<br>STREET   |  | CITY OR TOWN  |  | COUNTY  |  | STATE   |  |
| 22. I certify that (I) (this hospital) attended the deceased from <u>Dec 2</u> 19 <u>79</u> , to <u>Dec 7</u> 19 <u>79</u> , that (I) (we) last saw the deceased alive on <u>Dec 7</u> 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. |  |   |  |   |  |   |  |   |  |   |  |
| 22a. SIGNATURE<br><u>E. Myers, M.D.</u>  |  |   |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>        |  |   |  | 22c. DATE SIGNED<br><u>Dec 7/79</u>   |  |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><u>DR E Myers</u>   |  |   |  | 22e. ADDRESS<br><u>900 CATON AVE. BALTIMORE, MD. 21229</u>  |  |   |  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)   |  | 23b. DATE   |  | 23c. NAME OF CEMETERY OR CREMATORY  |  | 23d. LOCATION<br>CITY OR TOWN   |  | COUNTY  |  | STATE   |  |
| burial   |  | 12/10/79  |  | Meadowridge Cemetery  |  | Dorsey  |  | Howard  |  | Maryland  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><u>Ambrose Funeral Home</u>  |  |   |  | ADDRESS<br><u>1388 Sulphur Spring Rd.</u>   |  | 25a. DATE REC'D. BY REGISTRAR<br><u>DEC 10 1979</u>   |  | 25b. REGISTRAR'S SIGNATURE<br><u>Robert A. Brady</u>  |  |   |  |



BALTIMORE CITY

ST. AGNES HOSPITAL

BALTIMORE

500 CATON AVE. BALTIMORE, MD. 21229

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL HOME. GIVE PAGE 4 TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR RECORDS. IF THE DEATH IS SUSPECTED, THIS CERTIFICATE SHOULD BE FILED WITHIN 24 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH   |  |   |  |  |  |   |  |  |  | REG. NO. 300468  |  |  |  |
|--|--|---|--|--|--|---|--|--|--|--|--|--|--|
| 1. FOR STATE REGISTRAR   |  | 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Helen Mary Obrycki |  |  |  |   |  |  |  | 2a. DATE OF DEATH KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR 12 2 19 79 |  | 2b. HOUR 3:56 P.M.   |  |
| 3. SEX Female  |  | 4. RACE White   |  | 5. DATE OF BIRTH MONTH DAY YEAR Jan. 14, 1922  |  | 6. AGE (IN YEARS LAST BIRTHDAY) 57 YRS.                       |  | 7. IF UNDER 24 HRS. MONTHS DAYS HOURS MIN.   |  | 2c. DATE PRONOUNCED DEAD 12 3 19 79  |  | 2d. HOUR 3:56 P.M.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania   |  |   |  | 7b. CITIZEN OF WHAT COUNTRY? USA   |  |   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City, MD.                         |  |
| 10. CITY OR TOWN OF DEATH Baltimore  |  |   |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 2447 N. Calvert Street |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF BUSINESS LIFE) Secretary   |  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY Bd. of Education                               |  |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |   |  |  |  |   |  |  |  | 13a. STATE Maryland  |  | 13b. COUNTY Baltimore  |  |
| 13c. CITY OR TOWN Baltimore  |  |   |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                   |  |   |  | 13e. STREET ADDRESS 2447 N. Calvert St.  |  |  |  |  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST Stanislaus Obrycki   |  |   |  |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Josephine Gajewski |  |  |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No  |  |   |  | 16b. SOCIAL SECURITY NO. 166-14-1561   |  |   |  | 17. INFORMANT ADDRESS Miss Genevieve T. Obrycki 3706 N. Charles  |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Thrombosis of vertebral & basilar arteries<br>4332<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last:<br>(b)<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)   |  |   |  |  |  |   |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                     |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).  |  |   |  |  |  |   |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  |   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |  |   |  |  |  |  |  | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |  |   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19   |  |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)  |  |  |  |  |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)  |  |   |  | 21f. LOCATION CITY OR TOWN COUNTY STATE  |  |  |  |  |  |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |  |   |  |  |  |   |  |  |  |  |  |  |  |
| ACTUAL SIGNATURE Virginia L. Dolan   |  |   |  | TITLE (SPECIFY) Assistant  |  |   |  | DATE SIGNED 12/4/79  |  |  |  |  |  |
| EXAMINER'S NAME (TYPE OR PRINT) Virginia L. Dolan, M.D.  |  |   |  | ADDRESS 111 Penn Street  |  |   |  |  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial   |  |   |  | 23b. DATE Dec. 6, 1979   |  |   |  | 23c. NAME OF CEMETERY OR CREMATORY Oaklawn   |  |  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE Graceland Pk, Balto. Co., Md.            |  |
| 24. FUNERAL DIRECTOR NAME Mitchell-Wiedefeld Home, Inc.  |  |   |  | ADDRESS 6500 York Rd. Balto., Md.  |  |   |  | 25a. DATE REC'D. BY REGISTRAR DEC 10 1979  |  |  |  | 25b. REGISTRAR'S SIGNATURE   |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |   |   |                                    |  |               |  |                |  |          |  |
|---|--|--|---|---|------------------------------------|--|---------------|--|----------------|--|----------|--|
| 1. FOR STATE REGISTRAR  |  | 7 9 3 0 4 6 9  |   | REG. NO.  |                                    |  |               |  |                |  |          |  |
| 1. DECEASED NAME (TYPE OR PRINT)  |  |  | FIRST MIDDLE LAST   |   |                                    | 2a. DATE OF DEATH  |               |  | MONTH DAY YEAR |  | 2b. HOUR |  |
| Richard H. O'Dea  |  |  |   |   |                                    | 12 7 79  |               |  | 6:10 PM        |  |          |  |
| 3. SEX  |  | 4. RACE  |   | 5. DATE OF BIRTH  |                                    | 6. AGE (IN YEARS LAST BIRTHDAY)  |               | IF UNDER 1 YEAR  |                | IF UNDER 24 HRS                              |          |  |
| Male  |  | White  |   | Dec. 3 1910   |                                    | 69   |               | MONTHS DAYS  |                | HOURS MIN.                                   |          |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  | 7b. CITIZEN OF WHAT COUNTRY?   |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                    | 9. BALTIMORE CITY OR COUNTY OF DEATH   |               |  |                |  |          |  |
| Baltimore   |  | U.S.A.   |   |   |                                    | Baltimore City MD.   |               |  |                |  |          |  |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |   |   |                                    | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                  |               | 12b. KIND OF BUSINESS OR INDUSTRY                              |                |  |          |  |
| Baltimore   |  | 737 S. Bond St.  |   |   |                                    | Clerk Balto. City  |               |  |                |  |          |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |  |   | 13a. CITY OR TOWN   |                                    | 13b. INSIDE CITY LIMITS?   |               | 13c. STREET ADDRESS  |                |  |          |  |
| 13a. STATE  |  |  |   | 13b. COUNTY   |                                    | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>            |               | 737 S. Bond St.  |                |  |          |  |
| Maryland  |  |  |   | Baltimore   |                                    |  |               |  |                |  |          |  |
| 14. FATHER'S NAME   |  |  |   | 15. MOTHER'S MAIDEN NAME  |                                    |  |               |  |                |  |          |  |
| FIRST MIDDLE LAST   |  |  |   | FIRST MIDDLE LAST   |                                    |  |               |  |                |  |          |  |
| Thomas O'Dea  |  |  |   | Catherine Rainey  |                                    |  |               |  |                |  |          |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)   |  |  |   | 16b. SOCIAL SECURITY NO.  |                                    | 17. INFORMANT ADDRESS  |               |  |                |  |          |  |
| no  |  |  |   | 216-28-1688   |                                    | Mrs. Helen O'Dea, 737 S. Bond St.  |               |  |                |  |          |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY.   |  |  |   |   |                                    |  |               |  |                | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |          |  |
| IMMEDIATE CAUSE (a) ASHD  |  |  |   |   |                                    |  |               |  |                |  |          |  |
| 4140  |  |  |   |   |                                    |  |               |  |                |  |          |  |
| DUE TO, OR AS A CONSEQUENCE OF  |  |  |   |   |                                    |  |               |  |                |  |          |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.  |  |  |   |   |                                    |  |               |  |                |  |          |  |
| DUE TO, OR AS A CONSEQUENCE OF  |  |  |   |   |                                    |  |               |  |                |  |          |  |
| (c)   |  |  |   |   |                                    |  |               |  |                |  |          |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |  |   |   |                                    |  |               |  |                |  |          |  |
| 19a. DATE OF OPERATION  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                    |   |                                    | 20a. AUTOPSY?  |               | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |                |  |          |  |
|   |  |  |   |   |                                    | YES <input type="checkbox"/> NO <input type="checkbox"/>                       |               | YES <input type="checkbox"/> NO <input type="checkbox"/>       |                |  |          |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  | 21b. TIME OF INJURY   |   |                                    | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |               |  |                |  |          |  |
|   |  |  | HOUR A.M. MONTH DAY YEAR  |   |                                    |  |               |  |                |  |          |  |
|   |  |  | P.M. 19   |   |                                    |  |               |  |                |  |          |  |
| 21d. INJURY OCCURRED  |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   |                                    | 21f. LOCATION  |               |  |                |  |          |  |
| WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |  |   |   |                                    | STREET CITY OR TOWN COUNTY STATE   |               |  |                |  |          |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death. |  |  |   |   |                                    |  |               |  |                |  |          |  |
| 22b. SIGNATURE  |  |  |   |   |                                    | DEGREE   |               | 22c. DATE SIGNED   |                |  |          |  |
| Marshall S. Bedline, MD   |  |  |   |   |                                    |  |               | 12/8/79  |                |  |          |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  |  |   |   |                                    | 22e. ADDRESS   |               |  |                |  |          |  |
| Marshall S. Bedline, MD   |  |  |   |   |                                    | 1205 York Rd, Lutherville, 21093   |               |  |                |  |          |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   |  |  | 23b. DATE   |   | 23c. NAME OF CEMETERY OR CREMATORY |  | 23d. LOCATION |  | COUNTY STATE   |  |          |  |
| Burial  |  |  | Dec. 10, 1979   |   | New Cathedral Cemetery             |  | Baltimore     |  | Md.            |  |          |  |
| 24. FUNERAL DIRECTOR NAME   |  |  |   |   |                                    | 25a. DATE REC'D. BY REGISTRAR  |               | 25b. REGISTRAR'S SIGNATURE                                     |                |  |          |  |
| Lilly & Zeiler, Inc. 1901 Eastern Ave.  |  |  |   |   |                                    | DEC 10 1979  |               | Lilly & Zeiler, Inc.   |                |  |          |  |



DEC 10 1979

U.S. DEPARTMENT OF JUSTICE  
FEDERAL BUREAU OF INVESTIGATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 12 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  |   |  |  |  |  |  | 7 9 3 0 4 7 0       |     |            |  |
|--|--|--|--|---|--|--|--|--|--|---------------------|-----|------------|--|
| 1. FOR STATE REGISTRAR   |  | REG. NO.   |  |   |  |  |  |  |  |                     |     |            |  |
| 1. DECEASED NAME (TYPE OR PRINT)   |  | FIRST  |  | MIDDLE  |  | LAST   |  | 2a. DATE OF DEATH  |  | MONTH               | DAY | YEAR       | 2b. HOUR                                     |
| EDWIN  |  | A  |  |   |  | O'Doherty  |  | 12-01-75   |  |                     |     |            | 2:25 PM                                      |
| 3 SEX  |  | 4 RACE   |  | 5. DATE OF BIRTH  |  | 6 AGE (IN YEARS LAST BIRTHDAY)   |  | IF UNDER 1 YEAR  |  | IF UNDER 24 HRS     |     |            |  |
| male   |  | Caucasian  |  | MONTH 2 DAY 11 YEAR 94  |  | 85 YRS   |  | MONTHS   |  | DAYS                |     | HOURS MIN. |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH  |  |  |  |                     |     |            |  |
| Baltimore, Maryland  |  | USA  |  |   |  | Baltimore, MD.   |  |  |  |                     |     |            |  |
| 10. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)   |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |  |  |                     |     |            |  |
| Baltimore  |  | Bon Secours Hospital   |  | Ret. Policeman  |  | Baltimore City   |  |  |  |                     |     |            |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  | 13a. STATE   |  | 13b. COUNTY   |  | 13c. CITY OR TOWN  |  | 13d. INSIDE CITY LIMITS?                                       |  | 13e. STREET ADDRESS |     |            |  |
| Md.  |  |  |  | Balto.  |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                |  | 11 S. Woodington Road  |  |                     |     |            |  |
| 14. FATHER'S NAME  |  | FIRST  |  | MIDDLE  |  | LAST   |  | 15. MOTHER'S MAIDEN NAME                                       |  | FIRST               |     | MIDDLE     |  |
| Daniel   |  |  |  |   |  | O'Doherty  |  | Isabelle   |  |                     |     | Connelly   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)  |  | 16b. SOCIAL SECURITY NO.   |  | 17 INFORMANT  |  | ADDRESS  |  |  |  |                     |     |            |  |
| yes  |  | 1918   |  | 226-36-1531   |  | 1011 Fidelity Building Balto. Md. 21201  |  |  |  |                     |     |            |  |
|  |  |  |  |   |  | Mr. Patrick O'Doherty  |  |  |  |                     |     |            |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY.   |  |  |  |   |  |  |  |  |  |                     |     |            | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| IMMEDIATE CAUSE (a) Acute Lymphatic leukemia   |  |  |  |   |  |  |  |  |  |                     |     |            | Days   |
| 2040   |  |  |  |   |  |  |  |  |  |                     |     |            |  |
| DUE TO, OR AS A CONSEQUENCE OF   |  |  |  |   |  |  |  |  |  |                     |     |            |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last  |  |  |  |   |  |  |  |  |  |                     |     |            |  |
| DUE TO, OR AS A CONSEQUENCE OF   |  |  |  |   |  |  |  |  |  |                     |     |            |  |
| (c)  |  |  |  |   |  |  |  |  |  |                     |     |            |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)                 |  |  |  |   |  |  |  |  |  |                     |     |            |  |
| ASCVD - Atherosclerosis  |  |  |  |   |  |  |  |  |  |                     |     |            |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   |  | 20a. AUTOPSY?  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |  |                     |     |            |  |
|  |  |  |  |   |  | YES <input type="checkbox"/> NO <input type="checkbox"/>                           |  | YES <input type="checkbox"/> NO <input type="checkbox"/>       |  |                     |     |            |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) |  | 21b. TIME OF INJURY  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |  |  |                     |     |            |  |
|  |  | HOUR A.M. MONTH DAY YEAR   |  |   |  |  |  |  |  |                     |     |            |  |
|  |  | P.M. 19  |  |   |  |  |  |  |  |                     |     |            |  |
| 21d. INJURY OCCURRED   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  | 21f. LOCATION   |  | CITY OR TOWN   |  | COUNTY   |  | STATE               |     |            |  |
| WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |  |  |   |  |  |  |  |  |                     |     |            |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 11-30-1975 to 12-01-1975, that (I) (we) lost                                    |  |  |  |   |  |  |  |  |  |                     |     |            |  |
| saw the deceased alive on 12-01-1975, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated                |  |  |  |   |  |  |  |  |  |                     |     |            |  |
| above, (I) (we) (did) (did not) view the body after death.   |  |  |  |   |  |  |  |  |  |                     |     |            |  |
| 22b. SIGNATURE   |  | DEGREE   |  | ATTENDING PHYSICIAN   |  | MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED   |  |                     |     |            |  |
| [Signature]  |  | MD   |  |   |  |  |  | 12-01-75   |  |                     |     |            |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  | 22e. ADDRESS   |  |   |  |  |  |  |  |                     |     |            |  |
| Francisco F. ALBUQUERQUE   |  | 8548 Edgemoor Rd Pasadena Md 21122   |  |   |  |  |  |  |  |                     |     |            |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY  |  | 23d. LOCATION  |  | CITY OR TOWN   |  | COUNTY              |     | STATE      |  |
| Burial   |  | Dec. 5, 1979   |  | New Cathedral Cem.  |  | Balto.   |  |  |  |                     |     | Md.        |  |
| 24. FUNERAL DIRECTOR   |  | 25a. DATE REC'D. BY REGISTRAR  |  | 25b. REGISTRAR'S SIGNATURE  |  |  |  |  |  |                     |     |            |  |
| G. Truman Schwab 5151 Balto. National Pike Balto. Md. 21229  |  | DEC 6 1979   |  | [Signature]   |  |  |  |  |  |                     |     |            |  |

Waco, Texas

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |                 |   |  |   |  |  |                               | 79  | 30471 |   |  |                     |  |
|--|--|---|-----------------|---|--|---|--|--|-------------------------------|---|-------|---|--|---------------------|--|
| FOR<br>1 - STATE REGISTRAR   |  |   |                 |   |  |   |  |  |                               | REG. NO.                                  |       |   |  |                     |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  |   | FIRST<br>THOMAS |   |  | MIDDLE<br>A.  |  |  | LAST<br>O'DONNELL (BR. WARIN) |   |       | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>12/12/79 |  | 2b. HOUR<br>10:55am |  |
| 3 SEX<br>M   |  | 4 RACE<br>WHITE   |                 | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>7 2 04  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>75 YRS   |  | IF UNDER 1 YEAR<br>MONTHS DAYS   |                               | IF UNDER 24 HRS<br>HOURS MIN              |       |   |  |                     |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>MD  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |                 | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD.  |  |  |                               |   |       |   |  |                     |  |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>ST. AGNES HOSPITAL |                 |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Teaching Brother  |  | 12b. KIND OF BUSINESS OR INDUSTRY  |                               |   |       |   |  |                     |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  |   |                 | 13a. STATE<br>MD  |  | 13b. COUNTY<br>BALTO.   |  | 13c. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |                               | 13d. STREET ADDRESS<br>4403 FREDERICK AVE |       |   |  |                     |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>THOMAS O'DONNELL   |  |   |                 | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>MARY KANE  |  |   |  |  |                               |   |       |   |  |                     |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>129-42-0605  |                 | 17. INFORMANT<br>BRO. CARLOS  |  | ADDRESS<br>4403 FREDERICK AVE.  |  |  |                               |   |       |   |  |                     |  |
| 11. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>cardiorespiratory arrest</u><br>1629<br>DUE TO, OR AS A CONSEQUENCE OF (b) <u>Ca. lung</u><br>DUE TO, OR AS A CONSEQUENCE OF (c) <u>Ca. lung</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. |  |   |                 |   |  |   |  |  |                               |   |       | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH    |  |                     |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)<br><u>Progressive debilitation - malnutrition</u>  |  |   |                 |   |  |   |  |  |                               |   |       |   |  |                     |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><u>Ca. lung (lef)</u>   |                 |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                               |   |       |   |  |                     |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |                 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |  |   |  |  |                               |   |       |   |  |                     |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |                 | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |  |                               |   |       |   |  |                     |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>12/10</u> 19 <u>79</u> , to <u>12/12</u> 19 <u>79</u> , that (I) (we) lost saw the deceased alive on <u>12/10</u> 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                        |  |   |                 |   |  |   |  |  |                               |   |       |   |  |                     |  |
| 22b. SIGNATURE<br><u>[Signature]</u>   |  | DEGREE  |                 |   |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  |  |                               | 22c. DATE SIGNED                          |       |   |  |                     |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><u>Rosa Paul</u>  |  | 22e. ADDRESS<br><u>St. Agnes Hospital</u>   |                 |   |  |   |  |  |                               |   |       |   |  |                     |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>BURIAL   |  | 23b. DATE<br>12-15-79   |                 | 23c. NAME OF CEMETERY OR CREMATORY<br>NEW CATHEDRAL   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>BALTO. MD.  |  |  |                               |   |       |   |  |                     |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>WEBER FUNERAL HOME. EDMONDSON  |  | ADDRESS<br>5311   |                 | 25a. DATE REC'D. BY REGISTRAR<br>DEC 19 1979  |  | 25b. REGISTRAR'S SIGNATURE<br><u>[Signature]</u>  |  |  |                               |   |       |   |  |                     |  |

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WALSH

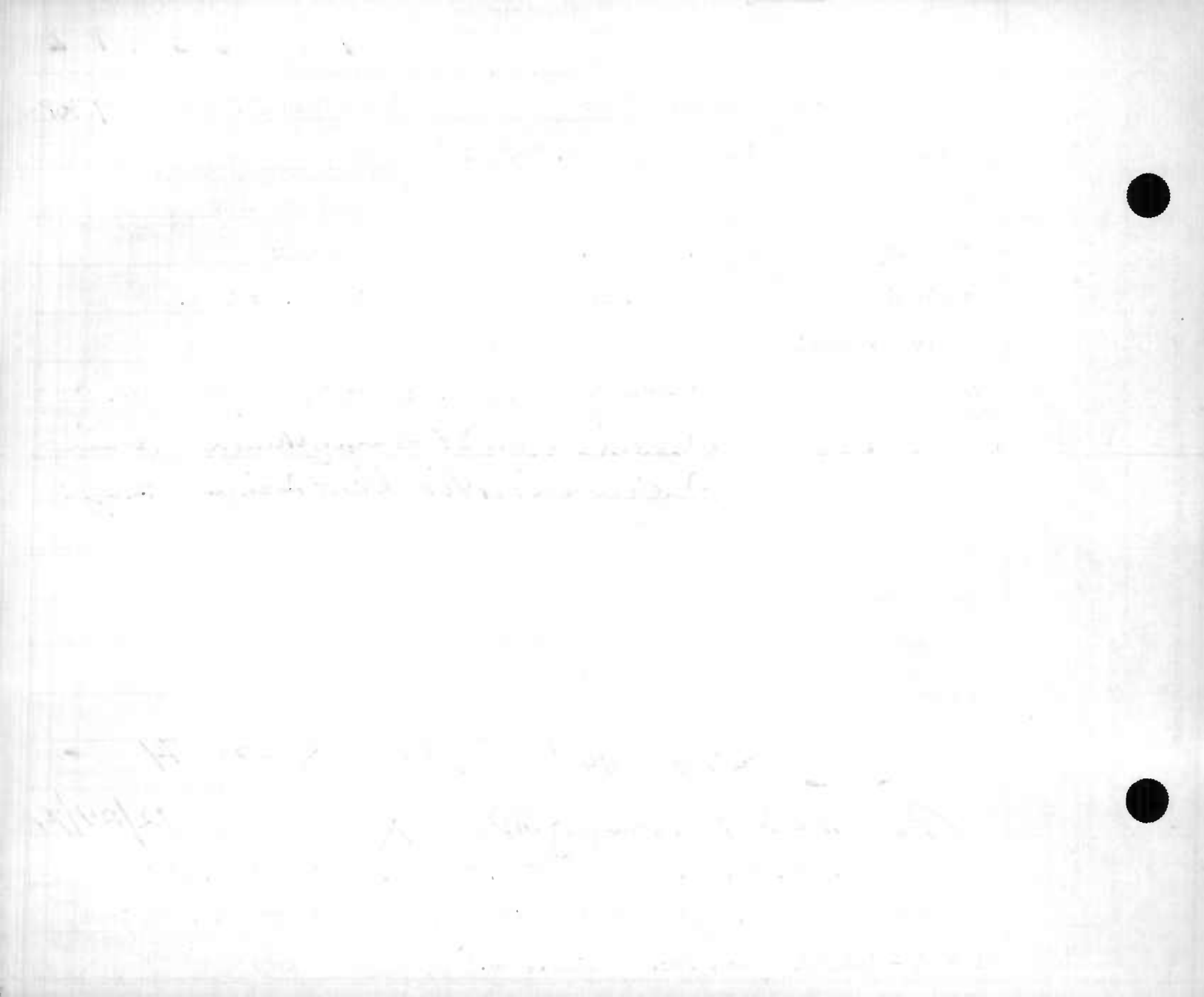


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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  |   |  |   |  |  |  |
|--|--|---|--|---|--|---|--|--|--|
| 1. FOR STATE REGISTRAR   |  | 79 30472<br>REG. NO.  |  |   |  |   |  |  |  |
| 1. DECEASED NAME (TYPE OR PRINT)   |  | FIRST MIDDLE LAST<br>ROSA PAULINA OLEFS   |  |   |  | 2a. DATE OF DEATH MONTH DAY YEAR<br>DECEMBER 22, 1979   |  | 2b. HOUR<br>7:30 P.M.  |  |
| 3. SEX<br>Female   |  | 4. RACE<br>White  |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>Dec. 10, 1883  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>96 YRS.  |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.                                      |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>3100 St. Paul St. |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Homemaker                      |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  |   |  |   |  |   |  |  |  |
| 13a. STATE<br>Maryland   |  | 13b. COUNTY   |  | 13c. CITY OR TOWN<br>Baltimore  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br>3100 St. Paul St.   |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>Gustav Bueschel   |  |   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Sara Ann Pope   |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>No  |  |   |  | 16b. SOCIAL SECURITY NO.<br>215-40-47787  |  | 17. INFORMANT ADDRESS<br>Robert A. Waidner 1209 Fidelity Bldg. 21201                            |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cardiac arrest - arrhythmia</u><br>4140<br>DUE TO, OR AS A CONSEQUENCE OF (b) <u>Arteriosclerotic heart disease</u><br>2 yr.<br>DUE TO, OR AS A CONSEQUENCE OF (c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>10 min.  |  |   |  |   |  |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |   |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                       |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>7/15</u> 19 <u>62</u> to <u>12/22</u> 19 <u>79</u> , that (I) <input checked="" type="checkbox"/> saw the deceased alive on <u>12/19</u> 19 <u>79</u> , and that in (my) <input checked="" type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above, (I) <input checked="" type="checkbox"/> (did) <input type="checkbox"/> (did not) view the body after death. |  |   |  |   |  |   |  |  |  |
| 22b. SIGNATURE<br><u>Norman R. Freeman, Jr. M.D.</u>   |  |   |  |   |  | 22c. DATE SIGNED<br>12/24/79  |  | 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Norman R. Freeman, Jr.  |  |
| 22e. ADDRESS<br>11 W. 29th St. Baltimore, Md. 21218  |  |   |  |   |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial  |  | 23b. DATE<br>Dec. 26, 1979  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Loudon Park   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br>Baltimore City, Maryland                             |  |  |  |
| 24. FUNERAL DIRECTOR NAME<br>Mitchell-Wiedefeld Home, Inc.   |  | ADDRESS<br>6500 York Rd. Balto., Md.  |  | 25a. DATE REC'D. BY REGISTRAR<br>DEC 27 1979  |  | 25b. REGISTRAR'S SIGNATURE<br><u>Anthony J. Brady</u>   |  |  |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |                      |   |  | 7 9 3 0 4 7 3<br>REG. NO.   |  |   |   |                         |
|---|----------------------|---|--|---|--|---|---|-------------------------|
| 1. DECEASED NAME (TYPE OR PRINT) <b>Gilbert</b>   |                      |   |  | 2a. DATE OF DEATH MONTH <b>12</b> DAY <b>10</b> YEAR <b>79</b>  |  |   |   | 2b. HOUR <b>5:00 PM</b> |
| 3. SEX <b>Male</b>  | 4. RACE <b>White</b> | 5. DATE OF BIRTH MONTH <b>9</b> DAY <b>12</b> YEAR <b>1917</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY) <b>62</b> YRS.  |  | IF UNDER 1 YEAR<br>MONTHS <b>0</b> DAYS <b>0</b>  |   |                         |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>   |                      | 7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>Balto. City</b> MD.   |   |                         |
| 10. CITY OR TOWN OF DEATH <b>Balto</b>  |                      | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Levinstate Hebrew Center + Hosp</b> |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Dispatcher</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY <b>TRUCKING CO.</b>   |   |                         |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |                      |   |  | 13a. STREET ADDRESS <b>19 Guild Hall Ct</b> 21207   |  |   |   |                         |
| 13a. STATE <b>MARYLAND</b>  |                      | 13b. COUNTY <b>BALTO.</b>   |  | 13c. CITY OR TOWN <b>Baltimore</b>  |  | 13d. INSIDE CITY LIMITS <b>YES</b> <input checked="" type="checkbox"/> NO <input type="checkbox"/>                      |   |                         |
| 14. FATHER'S NAME FIRST <b>JACOB</b> MIDDLE <b>OPPENHEIM</b>  |                      | 15. MOTHER'S MAIDEN NAME FIRST <b>SARAH</b> MIDDLE <b>FISHKIND</b>  |  |   |  |   |   |                         |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>YES</b>  |                      | 16b. SOCIAL SECURITY NO. <b>214-03-0992</b>   |  | 17. INFORMANT <b>MRS. AMELIA OPPENHEIM</b>  |  |   |   |                         |
|   |                      | <b>WWII-ARMY</b>  |  | <b>19 GUILDHALL CT. WOODLAWN, MD 21207</b>  |  |   |   |                         |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>METASTATIC LUNG CA</b><br><b>1629</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |                      |   |  |   |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>2 YRS.</b> |                         |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)   |                      |   |  |   |  |   |   |                         |
| 19a. DATE OF OPERATION  |                      | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |   |                         |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                      | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |  |   |   |                         |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |                      | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |   |   |                         |
| 22a. I certify that (this hospital) attended the deceased from <b>7/1/79</b> to <b>12/10/79</b> , that (we) last saw the deceased alive on <b>12/10/79</b> , and that in (our) opinion death occurred on the date and hour and from the causes stated above, (we) (did) (did not) view the body after death.  |                      |   |  |   |  |   |   |                         |
| 22b. SIGNATURE <b>Estrelita O. Ku</b>   |                      | DEGREE  |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>                  |  | 22c. DATE SIGNED <b>12/10/79</b>  |   |                         |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>ESTRELITA O. KU</b>  |                      | 22e. ADDRESS <b>LEVINSTATE HEBREW GERIATRIC CENTER + HOSPITAL</b>   |  |   |  |   |   |                         |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>   |                      | 23b. DATE <b>DEC. 11, 1979</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY <b>BETH ISRAEL</b>   |  | 23d. LOCATION CITY OR TOWN <b>BALTIMORE</b> COUNTY <b>MARYLAND</b> STATE <b>MARYLAND</b>                                |   |                         |
| 24. FUNERAL DIRECTOR <b>SOL LEVINSON &amp; BROS., INC.</b><br>NAME <b>6010 REISTERSTOWN RD.</b> ADDRESS <b>BALTO., MD 21215</b>   |                      |   |  | 25a. DATE REC'D. BY REGISTRAR <b>DEC 13 1979</b>  |  | 25b. REGISTRAR'S SIGNATURE <b>Rafaela M. Brady</b>  |   |                         |

BP \_\_\_\_\_



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Prior it may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

79 30474  
REG. NO.

|  |  |   |   |  |   |
|--|--|---|---|--|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>CLARENCE B. ORR   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>DEC. 4, 1979   |   | 2b. HOUR<br>M  |   |
| 3. SEX<br>MALE   | 4. RACE<br>WHITE   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>MAR. 13, 1922   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>57 YRS.   |   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>MD.   | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD.                           |   |
| 10. CITY OR TOWN OF DEATH<br>BASTO.  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>4407 FAIRDEL AVE. |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>SCHOOL TEACHER              |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>EDUCATION            |
| 13a. STATE<br>MD.  | 13b. COUNTY<br>—   | 13c. CITY OR TOWN<br>BASTO.   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br>4407 FAIRDEL AVE.                  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>JAMES MERION ORR   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>BESSIE LEE   |   |  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>YES  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>W.W.II   |   | 17. INFORMANT<br>ADDRESS<br>Mrs. Grace H. Orr 4407 Fairdel Ave.                      |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a): MYOCARDIAL INFARCTION<br>410-<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |   |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>IMMEDIATE |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)  |  |   |   |  |   |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  |   |   |  |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)       |   |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |   |
| 22a. I certify that (I) (was hospital) attended the deceased from 10:28, 1979, to 12:13, 1979, that (I) (we) last saw the deceased alive on 12-7-79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.  |  |   |   |  |   |
| 22b. SIGNATURE<br>J. Kleeman   |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>        |   | 22c. DATE SIGNED<br>12.13.79   |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>J. KLEEMAN  |  | 22e. ADDRESS<br>7600 OSLER DRIVE TOWSON   |   |  |   |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial  |  | 23b. DATE<br>12-14-1979   |   | 23c. NAME OF CEMETERY OR CREMATORY<br>DUBLIN Southern Ch.                            |   |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>DUBLIN MARYLAND MD.  |  | 23e. DATE REC'D. BY REGISTRAR<br>DEC 13 1979  |   |  |   |
| 24. FUNERAL DIRECTOR<br>NAME<br>Stanley Miller 7527 Harford Rd.  |  | 25. REGISTRAR'S SIGNATURE<br>Anthony McHenry  |   |  |   |

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DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

7 9 3 0 4 7 5

1- FOR  
STATE  
REGISTRAR

|   |  |   |  |  |  |  |  |  |  |
|---|--|---|--|--|--|--|--|--|--|
| 1 DECEASED NAME<br>(TYPE OR PRINT)<br><b>Gilbert</b>  |  | FIRST<br><b>Ortel</b>   |  | LAST<br><b>Ortel</b>   |  | 2a DATE OF DEATH<br>MONTH DAY YEAR<br><b>December 19, 1979</b>   |  | 2b HOUR<br><b>M</b>  |  |
| 3 SEX<br><b>Male</b>  |  | 4 RACE<br><b>White</b>  |  | 5 DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Jan 7 1897</b>   |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br><b>82</b> YRS  |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.                    |  |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Md.</b>  |  | 7b CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.   |  |  |  |
| 10 CITY OR TOWN OF DEATH<br><b>Balto.</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Baltimore City Hospital</b> |  |  |  | 12a USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>self-employed</b>                                    |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Garage</b>           |  |
| 13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a STATE<br><b>Md.</b>  |  | 13b COUNTY<br><b>Balto.</b>   |  | 13c. CITY OR TOWN<br><b>Balto.</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |  | 13e STREET ADDRESS<br><b>3231 Eastern Ave.</b>               |  |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>William Ortel</b>   |  | 15 MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Mary Smith</b>   |  |  |  |  |  |  |  |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>no</b>  |  | 16b SOCIAL SECURITY NO.<br><b>220-18-7242</b>   |  | 17 INFORMANT ADDRESS<br><b>Clara Ortel (wife) same address</b>   |  |  |  |  |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <b>ASCVD</b><br><b>4292</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____   |  |   |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>1 yr.</b> |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |   |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)   |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |  |  |  |  |
| 22a. I certify that (I) (the hospital) attended the deceased from <b>Dec. 7</b> , 19 <b>78</b> , to <b>Dec. 7</b> , 19 <b>79</b> , that (I) (we) last saw the deceased alive on <b>Dec. 7</b> , 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not view the body after death). |  |   |  |  |  |  |  |  |  |
| 22b. SIGNATURE<br><i>Dr. Melito Torres</i>  |  | DEGREE  |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                 |  |  |  | 22c. DATE SIGNED<br><b>12-20-79</b>                          |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Dr. Melito Torres</b>   |  | 22e. ADDRESS<br><b>441 S. Ellwood Ave.</b>  |  |  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>12/22/79</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Oak Lawn</b>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Balto. Md.</b>  |  |  |  |
| 24 FUNERAL DIRECTOR<br><b>Schimunek Funeral Home, Inc.</b>  |  | ADDRESS<br><b>3331 Brehms Lane Balto. Md. 21218</b>   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>DEC 21 1979</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><i>Patricia Melroy</i>   |  |  |  |

MEDICAL CERTIFICATION

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

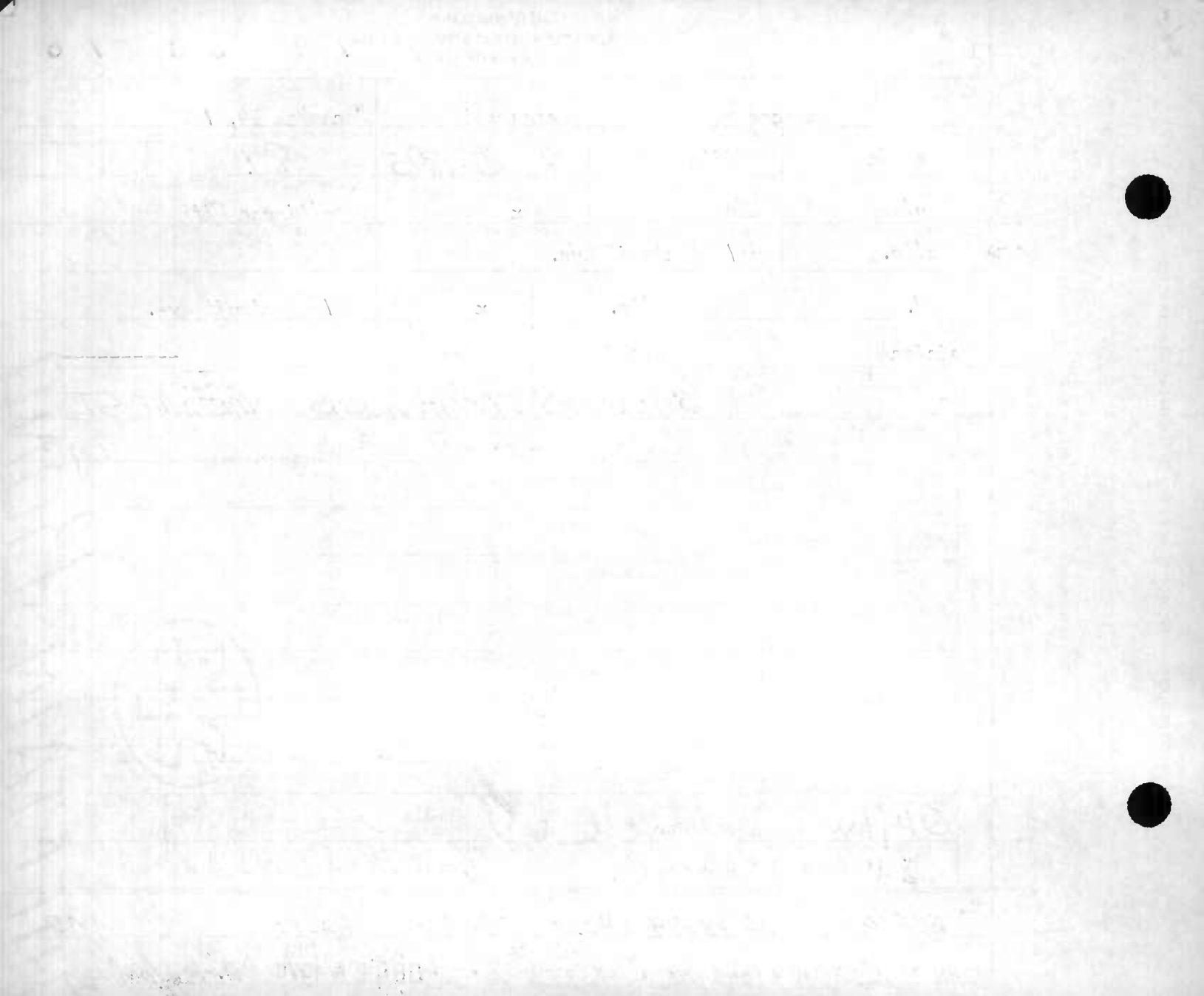


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |   |   |  |  |  |  |   |  |  |
|--|--|--|---|---|--|--|--|--|---|--|--|
| 1. FOR STATE REGISTRAR   |  |  |   |   | 7 9 3 0 4 7 6<br>REG. NO.                                    |  |  |  |   |  |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><i>Frances Ostrowski</i>  |  |  |   |   | 2a. DATE OF DEATH MONTH DAY YEAR<br><i>December 24, 1979</i> |  |  | 2b. HOUR<br>M  |   |  |  |
| 3. SEX<br><i>Female</i>  |  | 4. RACE<br><i>White</i>  |   | 5. DATE OF BIRTH MONTH DAY YEAR<br><i>9-15-1895</i>   |  | 6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS<br><i>84</i> YRS   |  | IF UNDER 1 YEAR IF UNDER 24 HRS<br>MONTHS DAYS HOURS MIN |   |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><i>Poland</i>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><i>USA</i>   |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><i>Baltimore City</i> MD.  |  |  |   |  |  |
| 10. CITY OR TOWN OF DEATH<br><i>Balto.</i>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><i>6616 Hartmut Ave.</i> |   |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |  | 12b. KIND OF BUSINESS OR INDUSTRY                        |   |  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE <i>MD.</i> 13b. COUNTY   |  |  |   |   | 13c. CITY OR TOWN<br><i>Balto.</i>                           |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><i>6616 Hartmut Ave.</i>   |  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><i>Wojciech Merski</i>  |  |  |   |   | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><i>Ewa</i>     |  |  |  |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br><i>No</i>   |  | 16b. SOCIAL SECURITY NO.<br><i>217-16-6188</i>   |   | 17. INFORMANT ADDRESS<br><i>WANDA LUCAS 6616 HARTMUT ST</i>   |  |  |  |  |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Arterio subacute M.V. Dis.</i><br><i>4292</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |  |  |   |   |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><i>7 yrs</i>  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (i):   |  |  |   |   |  |  |  |  |   |  |  |
| 19a. DATE OF OPERATION   |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                    |   |  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>                       |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><i>19</i>           |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |  |   |  |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |  |   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>19 72</i> to <i>Dec 24</i> 19 <i>79</i> , that (I) (we) last saw the deceased alive on <i>Dec 24</i> 19 <i>79</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                           |  |  |   |   |  |  |  |  |   |  |  |
| 22b. SIGNATURE<br><i>Stephen P. MacKowiak M.D.</i>   |  |  |   |   |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED   |   |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><i>S.P. MACKOWIAK.</i>  |  |  |   |   |  | 22e. ADDRESS<br><i>6714 HOLAKIED AV</i>  |  |  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><i>BURIAL</i>   |  |  | 23b. DATE<br><i>12/28/79</i>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><i>HOLY ROSARY</i>     |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><i>BALTO</i> <i>MD</i>                            |  |   |  |  |
| 24. FUNERAL DIRECTOR NAME<br><i>JOHN M WIEBER &amp; SONS INC</i>   |  |  |   |   |  | ADDRESS<br><i>401 S. CHESTER ST</i>  |  | 25a. DATE REC'D. BY REGISTRAR<br><i>DEC. 28 1979</i>     |   | 25b. REGISTRAR'S SIGNATURE<br><i>Rafay K. B...</i> |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  |  |  |   |  |  |  | 7 9 3 0 4 7 7<br>REG. NO.   |  |  |  |
|--|--|---|--|--|--|---|--|--|--|---|--|--|--|
| 1. FOR STATE REGISTRAR   |  | 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br><b>AKA C. Earl Ott</b>  |  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>Dec 27 1979</b>  |  |  |  | 2b. HOUR<br><b>7 P.M.</b>   |  |  |  |
| 3 SEX<br><b>Male</b>   |  | 4 RACE<br><b>White</b>  |  | 5 DATE OF BIRTH MONTH DAY YEAR<br><b>Oct 18 1909</b>   |  | 6 AGE (IN YEARS LAST BIRTHDAY) YRS<br><b>70</b>   |  | IF UNDER 1 YEAR MONTHS DAYS<br><b>70</b>   |  | IF UNDER 24 HRS. HOURS MIN.<br><b>7 P.M.</b>  |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Md.</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.  |  |  |  |   |  |  |  |
| 10 CITY OR TOWN OF DEATH<br><b>Balto.</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>6111 Hamilton Ave.</b> |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Lab Tech.</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>VA Hospital</b>                                      |  |   |  |  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE<br><b>Md.</b>   |  |   |  | 13b. COUNTY<br><b>Balto.</b>   |  | 13c. CITY OR TOWN<br><b>Balto.</b>  |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>6111 Hamilton Ave.</b>  |  |  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>Christian Ott</b>  |  |   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>Mary Gray</b>   |  |   |  |  |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>yes</b>   |  |   |  | 16b. SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES)<br><b>WW II 220-30-3072</b>  |  | 17. INFORMANT ADDRESS<br><b>Mary Ott (wife) same address</b>  |  |  |  |   |  |  |  |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Chronic Coronary Artery Disease</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>410-15 yrs.</b>  |  |   |  |  |  |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>Minutes</b>  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><b>Residuals Rt. Hemiparesis Diabetes M.</b>  |  |   |  |  |  |   |  |  |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  |   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><b>19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |   |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  |   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |  |  |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>3-25</b> , 19 <b>58</b> , to <b>12-27</b> , 19 <b>79</b> , that (I) (we) last saw the deceased alive on <b>12-14</b> , 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death. |  |   |  |  |  |   |  |  |  |   |  |  |  |
| 22b. SIGNATURE<br><b>William P. Benson, Jr. M.D.</b>   |  |   |  |  |  | DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br><b>12-28-79</b>  |  |   |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Dr. William Benson</b>   |  |   |  |  |  | 22e. ADDRESS<br><b>3506 N. Calvert St.</b>  |  |  |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Cremation</b>  |  |   |  | 23b. DATE<br><b>12/29/79</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Greenmount</b>   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><b>Balto. Md.</b>                                 |  |   |  |  |  |
| 24. FUNERAL DIRECTOR<br><b>Schamunek Funeral Home, Inc.</b>  |  |   |  | 24b. ADDRESS<br><b>3321 Brehms Lane Balto. Md. 21213</b>   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>DEC 28 1979</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>   |  |   |  |  |  |





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death, and be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  |   |  |   |  |   |  |  |  |
|--|--|--|--|---|--|---|--|---|--|--|--|
| 1. FOR<br>STATE<br>REGISTRAR   |  | 7 9 3 0 4 7 8<br>REG. NO.  |  |   |  |   |  |   |  |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  | FIRST  |  | MIDDLE  |  | LAST  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR   |  | 2b. HOUR   |  |
| Alicia F.  |  | Otto   |  |   |  |   |  | 12-13-79  |  | 12N  |  |
| 3. SEX   |  | 4. RACE  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR  |  | 6. AGE (IN YEARS LAST BIRTHDAY)   |  | IF UNDER 1 YEAR<br>MONTHS DAYS  |  | IF UNDER 24 HRS<br>HOURS MIN.                                    |  |
| F  |  | W  |  | Aug. 8, 1889  |  | 90 YRS.   |  |   |  |  |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN<br>COUNTRY)  |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.                                      |  |   |  |  |  |
| Md.  |  | USA  |  |   |  |   |  |   |  |  |  |
| 10. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)                                  |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)  |  | 12b. KIND OF BUSINESS OR<br>INDUSTRY  |  |   |  |  |  |
| Baltimore  |  | Edgewood Nursing Home  |  | Homemaker   |  |   |  |   |  |  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  | 13a. STATE   |  | 13b. CITY OR TOWN   |  | 13c. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13d. STREET ADDRESS   |  |  |  |
| Md.  |  | Baltimore  |  | Baltimore   |  |   |  | 2515 Hillcrest Ave.   |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST  |  |   |  |   |  |   |  |  |  |
| John Downey  |  | Theresa Canty  |  |   |  |   |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)  |  | 17. INFORMANT<br>ADDRESS  |  |   |  |   |  |  |  |
| No   |  | 212 05 6224  |  | Mrs. Dorothy Taneyhill  |  | 119 Overbrook Rd.   |  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Terminal pneumonia</u><br>429.2<br>DUE TO, OR AS A CONSEQUENCE OF:<br>(b) <u>Arteriosclerotic Cardiovascular Disease</u><br>107.2<br>DUE TO, OR AS A CONSEQUENCE OF:<br>(c) <u></u>   |  |  |  |   |  |   |  |   |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br><u>2 days</u> |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):   |  |  |  |   |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                       |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |  |   |  |   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |   |  |  |  |
|  |  |  |  |   |  |   |  |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>Mar 10</u> 19 <u>78</u> to <u>Dec 13</u> 19 <u>79</u> , that (I) (we) lost<br>saw the deceased alive on <u>Dec 12</u> 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death. |  |  |  |   |  |   |  |   |  |  |  |
| 22b. SIGNATURE   |  | DEGREE   |  |   |  |   |  | 22c. DATE SIGNED  |  |  |  |
| <u>Fredrick J. Vollmer, M.D.</u>   |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  |   |  |   |  | 12-13-79  |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  | 22e. ADDRESS   |  |   |  |   |  |   |  |  |  |
| Fred J. Vollmer  |  | 6100 York Rd BALTIMORE MD 21212  |  |   |  |   |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)   |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE  |  |   |  |  |  |
| Burial   |  | 12/15/79   |  | Baltimore Cemetery  |  | Baltimore, Md.  |  |   |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS   |  | 25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE   |  |   |  |   |  |   |  |  |  |
| MITCHELL-WIEDEFELD HOME, INC. 6500 York Rd.  |  | DEC 18 1979 <u>Jeffrey McCreedy</u>  |  |   |  |   |  |   |  |  |  |

8 1 6 . . .

~~SECRET~~



REF ID: A6210



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  |   |  |  |  |  |  | 7 9 3 0 4 7 9<br>REG. NO.  |  |
|--|--|---|--|---|--|--|--|--|--|--|--|
| 1- FOR STATE REGISTRAR   |  | 1 DECEASED NAME (TYPE OR PRINT) <i>Julia Ann Owens</i>  |  |   |  |  |  | 2a DATE OF DEATH MONTH DAY YEAR <i>12 7 79</i>                                   |  | 2b HOUR <i>4:20 PM</i>   |  |
| 3 SEX <i>Female</i>  |  | 4 RACE <i>Black</i>   |  | 5 DATE OF BIRTH MONTH DAY YEAR <i>12 13 41</i>  |  | 6 AGE (IN YEARS LAST BIRTHDAY) <i>37</i> YRS.                              |  | IF UNDER 1 YEAR MONTHS DAYS  |  | IF UNDER 74 HRS HOURS MIN.   |  |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Georgia</i>  |  | 7b CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>   |  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>          |  | 9 BALTIMORE CITY OR COUNTY OF DEATH <i>Baltimore City</i> MD.              |  |  |  |  |  |
| 10 CITY OR TOWN OF DEATH <i>Baltimore</i>  |  | 11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>U.S. P.H.S. Hospital</i> |  |   |  | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>H.W.F.</i> |  | 12b KIND OF BUSINESS OR INDUSTRY   |  |  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  |   |  | 13a STATE <i>Md.</i>  |  | 13b COUNTY   |  | 13c CITY OR TOWN <i>Baltimore</i>  |  | 13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |  |
| 14 FATHER'S NAME FIRST MIDDLE LAST <i>Vernon JACKSON</i>   |  |   |  | 15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Edwina Cook</i>  |  |  |  |  |  |  |  |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i>   |  |   |  | 16b SOCIAL SECURITY NO. <i>255 742 190</i>  |  | 17 INFORMANT ADDRESS <i>Charles Owens 534 Chateau Ave</i>                  |  |  |  |  |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiac Failure</i>  |  |   |  |   |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>12 hours</i>   |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last  |  |   |  |   |  |  |  |  |  | DUE TO, OR AS A CONSEQUENCE OF (b) <i>Metastatic Malignant Melanoma</i> <i>6 years</i>                                 |  |
| DUE TO, OR AS A CONSEQUENCE OF (c)   |  |   |  |   |  |  |  |  |  |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (g) <i>Malnutrition, ascites, pleural effusion, pericardial effusion</i>  |  |   |  |   |  |  |  |  |  |  |  |
| 19a DATE OF OPERATION  |  |   |  | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  |  | 20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   |  | 21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <i>19</i>  |  |  |  | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)    |  |  |  |
| 21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |   |  | 21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  |  |  | 21f LOCATION STREET CITY OR TOWN COUNTY STATE                                    |  |  |  |
| 22a I certify that (I) (this hospital) attended the deceased from <i>Nov 30</i> 19 <i>79</i> , to <i>Dec 7</i> 19 <i>79</i> , that (I) (we) last saw the deceased alive on <i>Dec 7</i> 19 <i>79</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (do) view the body after death. |  |   |  |   |  |  |  |  |  |  |  |
| 22b SIGNATURE <i>Judith Dillman</i> DEGREE <i>M.D.</i>   |  |   |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  |  |  | 22c DATE SIGNED <i>12/8/79</i>   |  |  |  |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT) <i>Judith Dillman, M.D.</i>   |  |   |  | 22e ADDRESS <i>U.S.P.H.S. Hospital Baltimore</i>  |  |  |  |  |  |  |  |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>   |  |   |  | 23b DATE <i>12/14/79</i>  |  | 23c NAME OF CEMETERY OR CREMATORY <i>King Mem. PK.</i>                     |  | 23d LOCATION CITY OR TOWN COUNTY STATE <i>Woodlawn Balto. Md.</i>                |  |  |  |
| 24 FUNERAL DIRECTOR NAME <i>Chatman F. Jr.</i>   |  |   |  | ADDRESS <i>1701 McCullough St.</i>  |  |  |  | 25a DATE REC'D. BY REGISTRAR <i>DEC 10 1979</i>                                  |  | 25b REGISTRAR'S SIGNATURE <i>Ruby McBrady</i>  |  |

81.66



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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  |  |  |   |  |  |  |
|--|--|--|--|--|--|---|--|--|--|
| 1. FOR<br>STATE<br>REGISTRAR   |  | 7 9 3 0 4 8 0  |  | REG. NO.   |  |   |  |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>LAWRENCE D. OWENS</b>  |  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>DECEMBER 14, 1979</b>  |  | 2b. HOUR<br><b>11:50PM</b>  |  |  |  |
| 3. SEX<br><b>MALE</b>  |  | 4. RACE<br><b>NEGRO</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>FEB. 2, 1963</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>16</b> YRS.   |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MARYLAND</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>UNITED STATES</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.                               |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>THE JOHNS HOPKINS HOSPITAL</b> |  |  |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>STUDENT</b>              |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>SCHOOL</b>   |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>MARYLAND</b>   |  | 13b. COUNTY<br><b>ANNE ARUNDEL</b>   |  | 13c. CITY OR TOWN<br><b>FORT MEADE</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>1759 CIRCLE ROAD,</b>  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>JOHN OWENS</b>  |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>DOROTHY HILL</b>   |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>215-88-8598</b>   |  | 17. INFORMANT<br>ADDRESS<br><b>MRS. DOROTHY OWENS / 1759 CIRCLE ROAD</b>   |  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Respiratory failure</b><br><b>2399</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>metastatic tumor</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b></b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. |  |  |  |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>~ 2 yrs</b>   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).   |  |  |  |  |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>12/10</b> 19 <b>79</b> to <b>12/14</b> 19 <b>79</b> , that (I) (we) lost<br>saw the deceased alive on <b>12/14</b> 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                               |  |  |  |  |  |   |  |  |  |
| 22b. SIGNATURE<br><b>Sidney D. Gottlieb MD</b>   |  |  |  | DEGREE<br><b>MD</b>  |  |   |  | 22c. DATE SIGNED<br><b>12/15/79</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>SIDNEY D. GOTTIEB</b>  |  |  |  | 22e. ADDRESS<br><b>DEPT MED, JHHT, Balto MD</b>  |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>BURIAL</b>  |  | 23b. DATE<br><b>DEC. 18, 1979</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>HARMONY CEMETERY</b>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Lanndon MARYLAND</b>                           |  |  |  |
| 24. FUNERAL DIRECTOR<br><b>ROLLINS FUNERAL HOME, INC.</b>  |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>DEC 20 1979</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>  |  |  |  |
| ADDRESS<br><b>433 HUNT PLACE, N. E. WASH. D.C.</b>   |  |  |  |  |  |   |  |  |  |

PP 85 621 0 CM 000

1950 CIRCLE ROAD  
Baltimore, Md.  
JAN 2, 1963  
D. E. CHASE  
11:00 AM

1950 CIRCLE ROAD  
Baltimore, Md.  
JAN 2, 1963  
D. E. CHASE  
11:00 AM

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

7 9 30481

REG. NO.

1 - FOR  
STATE  
REGISTRAR

|   |  |   |   |  |  |
|---|--|---|---|--|--|
| 1. DECEASED NAME (TYPE OR PRINT)<br>FIRST MARY U. LAST OWENS  |  |   | 2a. DATE OF DEATH<br>MONTH 12 DAY 5 YEAR 79   |  | 2b. HOUR<br>8:00 A.M.  |
| 3. SEX<br>Female  | 4. RACE<br>BLACK   | 5. DATE OF BIRTH<br>MONTH 9 DAY 26 YEAR 1897  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>82 YRS   |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Balt. Md.  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City, MD.                                     |  |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Touhidat Hosp. | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Homemaker  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |  |
| 13a. STATE<br>Maryland  | 13b. COUNTY<br>BALTO.  | 13c. CITY OR TOWN<br>BALTO.   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS<br>4005 Springdale Ave                                     |  |
| 14. FATHER'S NAME<br>FIRST George MIDDLE LAST Johnson   | 15. MOTHER'S MAIDEN NAME<br>FIRST Mary Catherine MIDDLE LAST Johnson   |   | 16. ADDRESS<br>215-12-7716 McLenard Owens 4821 Valley Forge Rd                                  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>NO   | 16b. SOCIAL SECURITY NO.<br>215-12-7716  | 17. INFORMANT<br>McLenard Owens   |   |  |  |
| 18. CAUSE OF DEATH Enter only one cause per part. I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Septicemia<br>7070<br>DUE TO, OR AS A CONSEQUENCE OF (b) Pneumonia<br>DUE TO, OR AS A CONSEQUENCE OF (c) Pneumonia<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. |  |   |   |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |   |   |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>      | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 12-5-79 to 12-5-79, that (I) (we) last saw the deceased alive on 12-5-79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.                 |  |   |   |  |  |
| 22b. SIGNATURE<br>Maureen A. Allen, M.D.  |  | DEGREE<br>M.D.  |   | 22c. DATE SIGNED<br>12-5-79  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Maureen A. Allen, Jr.  |  | 22e. ADDRESS<br>2600 Liberty Heights Ave.   |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial   | 23b. DATE<br>12-10-79  | 23c. NAME OF CEMETERY OR CREMATORY<br>Mt. Auburn Cem.   | 23d. LOCATION<br>Westport   | COUNTY<br>Gnd  | STATE  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Joseph L. Russ  |  | ADDRESS<br>2222 W. North Ave  |   | 25a. DATE REC'D. BY REGISTRAR<br>DEC 11 1979                                   | 25b. REGISTRAR'S SIGNATURE<br>Rory McHenry   |

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

11

*[Faint, mostly illegible handwritten text, possibly bleed-through from the reverse side of the page. Some words like "CO" and "TO" are visible.]*

*[Faint handwritten text at the bottom left corner.]*

UNIVERSITY OF CHICAGO  
LIBRARY

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 50M 1/76  
(VR A 15 (4))

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

7 9 3 0 4 8 2

REG. NO.

|  |  |   |  |  |              |   |  |  |           |                                  |  |
|--|--|---|--|--|--------------|---|--|--|-----------|----------------------------------|--|
| 1. FOR<br>STATE<br>REGISTRAR   |  | 1. DECEASED NAME<br>(TYPE OR PRINT)   |  | FIRST<br>Thomas  | MIDDLE<br>M. | LAST<br>OWENS   | 2a. DATE OF DEATH                          | MONTH<br>12  | DAY<br>23 | YEAR<br>79                       | 2b. HOUR<br>4 <sup>10</sup> AM               |
| 3. SEX<br>Male   | 4. RACE<br>White   | 5. DATE OF BIRTH  | MONTH<br>10  | DAY<br>5   | YEAR<br>18   | 6. AGE (IN YEARS LAST BIRTHDAY)   | 61   | IF UNDER 1 YEAR<br>MONTHS<br>DAYS  |           | IF UNDER 24 HRS<br>HOURS<br>MIN. |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>W. Virginia   | 7b. CITIZEN OF WHAT COUNTRY?<br>United States  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD. |  |              |   |  |  |           |                                  |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Baltimore City Hospital |   |  |  |              | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Mechanic                    | 12b. KIND OF BUSINESS OR INDUSTRY<br>- - - |  |           |                                  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  |   |  |  |              | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS<br>236 S. Duncan St.   |  |           |                                  |  |
| 13a. STATE<br>Maryland   | 13b. COUNTY<br>---   | 13c. CITY OR TOWN<br>Baltimore  |  |  |              |   |  |  |           |                                  |  |
| 14. FATHER'S NAME<br>FIRST John MIDDLE --- LAST Ownes  |  |   |  |  |              | 15. MOTHER'S MAIDEN NAME<br>FIRST Mary MIDDLE --- LAST Evans                                    |  |  |           |                                  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) NO  |  | 16b. SOCIAL SECURITY NO.<br>232-24-7819   |  | 17. INFORMANT<br>Sylvania Owens 236 S. Duncan St.                              |              |   |  |  |           |                                  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>CARDIAC ARREST - VENTRICULAR</u><br><u>4409</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>ATHEROSCLEROSIS</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>TACHYCARDIA</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |   |  |  |              |   |  |  |           |                                  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).   |  |   |  |  |              |   |  |  |           |                                  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  |              | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                       |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                 |           |                                  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |              |   |  |  |           |                                  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |              |   |  |  |           |                                  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost<br>saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.  |  |   |  |  |              |   |  |  |           |                                  |  |
| 22b. SIGNATURE<br><u>C. Hamann</u>   |  |   |  |  |              | DEGREE  |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |           | 22c. DATE SIGNED<br>12/23/79     |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>C. HAMANN   |  |   |  |  |              | 22e. ADDRESS<br>4940 EASTERN AV 21224   |  |  |           |                                  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial  |  | 23b. DATE<br>12-26-79   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>OakLawn Cemetery                         |              |   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>--- Baltimore, Md.   |           |                                  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Lilly & Zeiler Inc. 1901 Eastern Ave.  |  |   |  |  |              | 25a. DATE REC'D. BY REGISTRAR<br>DEC 27 1979  |  | 25b. REGISTRAR'S SIGNATURE<br><u>R. H. McCreedy</u>  |           |                                  |  |

MEDICAL CERTIFICATION

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

7 9 3 0 4 8 3

1- FOR  
STATE  
REGISTRAR

REG. NO.

|  |  |                     |   |   |  |   |  |  |  |   |                                |  |  |
|--|--|---------------------|---|---|--|---|--|--|--|---|--------------------------------|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>JENNIE</b>   |  |                     | FIRST MIDDLE LAST<br><b>PACK</b>  |   |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>DECEMBER 27, 1979</b>  |  |  | 2b. HOUR<br><b>5<sup>15</sup> P.M.</b>   |   |                                |  |  |
| 3. SEX<br><b>F</b>   |  | 4. RACE<br><b>B</b> |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>5-5-1900</b> |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>79</b> YRS.   |  |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.  |   | IF UNDER 24 HRS.<br>HOURS MIN. |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>BALTIMORE</b>  |  |                     | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>City</b> MD.  |   |                                |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>  |  |                     | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Montebello State Hospital</b> |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>House Wife</b>   |  |  | 12b. KIND OF BUSINESS OR INDUSTRY  |   |                                |  |  |
| 13a. STATE<br><b>MARYLAND</b>  |  |                     | 13b. CITY OR TOWN<br><b>BALTIMORE</b>   |   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  |  | 13e. STREET ADDRESS<br><b>1700 E. LANVALE Street</b>   |   |                                |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Joseph Townsend</b>   |  |                     | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Elizabeth Smith</b>   |   |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>   |  |  | 16b. SOCIAL SECURITY NO.   |   |                                | 17. INFORMANT<br><b>Elizabeth Groscham</b> ADDRESS<br><b>1700 E. LANVALE ST.</b> |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY.<br>IMMEDIATE CAUSE (a) <b>PNEUMONITIS</b><br>486-<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) _____<br>(c) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>DUE TO, OR AS A CONSEQUENCE OF           |  |                     |   |   |  |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>12 Hours</b> |                                |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) _____   |  |                     |   |   |  |   |  |  |  |   |                                |  |  |
| 19a. DATE OF OPERATION   |  |                     | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |                                |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |                     | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |   |                                |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |                     | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |   |                                |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>3/79</b> , 19 <b>76</b> , to <b>12/27</b> , 19 <b>79</b> , that (I) (we) last saw the deceased alive on <b>12/27</b> , 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |                     |   |   |  |   |  |  |  |   |                                |  |  |
| 22b. SIGNATURE<br><b>W. Alfred Gakenheimer</b> MD  |  |                     |   |   |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>        |  |  | 22c. DATE SIGNED<br><b>12/27/79</b>  |   |                                |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>W. ALFRED GAKENHEIMER</b>  |  |                     |   |   |  | 22e. ADDRESS<br><b>2201 ARGONNE DRIVE BALTIMORE MD. 21218</b>   |  |  |  |   |                                |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>BURIAL</b>  |  |                     | 23b. DATE<br><b>1-3-80</b>  |   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Westview MEM PARK</b>  |  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>CATONSVILLE MARYLAND</b>  |   |                                |  |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>William J. Spicer 1639 N. Broad Way</b>   |  |                     |   |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>DEC 31 1979</b>   |  |  | 25b. REGISTRAR'S SIGNATURE<br><b>Robert K. Kandy</b>   |   |                                |  |  |

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  |   |  |  |  |   |  |                                    |  |
|---|--|---|--|---|--|--|--|---|--|------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |  | FIRST   |  | MIDDLE  |  | LAST   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR   |  | 2b. HOUR                           |  |
| CAROLYN   |  | Louise  |  | PAGE  |  |  |  | DECEMBER 12 29 79   |  | 12:22 PM                           |  |
| 3 SEX   |  | 4 RACE  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR  |  | 6. AGE (IN YEARS LAST BIRTHDAY)  |  | IF UNDER 1 YEAR<br>MONTHS DAYS  |  | IF UNDER 24 HRS<br>HOURS MIN.      |  |
| F   |  | B   |  | 8 27 55   |  | 24 YRS.  |  |   |  |                                    |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)  |  | 7b. CITIZEN OF WHAT COUNTRY?  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH   |  |   |  |                                    |  |
| N.C.  |  | USA   |  |   |  | BALTIMORE CITY   |  |   |  | MD.                                |  |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)  |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |   |  |                                    |  |
| Balto.  |  | THE JOHNS HOPKINS HOSPITAL  |  |   |  |  |  |   |  |                                    |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  | 13a. STATE  |  | 13b. COUNTY   |  | 13c. CITY OR TOWN  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                       |  | 13e. STREET ADDRESS                |  |
| Md.   |  |   |  | Balto.  |  |  |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | Wakefield Rd<br>4712 Wakefield Rd. |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST   |  |   |  |  |  |   |  |                                    |  |
| Rufus   |  | Monroe  |  | Lillie  |  | Roseboro   |  |   |  |                                    |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)   |  | 17. INFORMANT   |  | ADDRESS  |  |   |  |                                    |  |
| No  |  |   |  | Charles Page  |  | 5316 Belleville Ave.   |  |   |  |                                    |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY.<br>IMMEDIATE CAUSE (a) <u>ASYSTOLE</u><br>396-<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>BACTERIAL ENDOCARDITIS</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>ARTIC &amp; VENTR REGULATION</u><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>5 mo |  |   |  |   |  |  |  |   |  |                                    |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)   |  |   |  |   |  |  |  |   |  |                                    |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |                                    |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |  |  |  |   |  |                                    |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |   |  |                                    |  |
|   |  |   |  |   |  |  |  |   |  |                                    |  |
| 22a. I certify that (this hospital) attended the deceased from <u>12/25</u> 19 <u>79</u> , to <u>12/29</u> 19 <u>79</u> , that (we) last saw the deceased alive on <u>12/29</u> 19 <u>79</u> , and that in (our) opinion death occurred on the date and hour and from the causes stated above. (we) (did) (not) view the body after death.                          |  |   |  |   |  |  |  |   |  |                                    |  |
| 22b. SIGNATURE<br><u>Elliott Israel</u>   |  |   |  | DEGREE<br><u>MD</u>   |  |  |  | 22c. DATE SIGNED<br><u>12/29/79</u>   |  |                                    |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><u>Elliott Israel</u>  |  |   |  | 22e. ADDRESS<br><u>601 N BROADWAY Balto 21205</u>   |  |  |  |   |  |                                    |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)  |  | 23b. DATE   |  | 23c. NAME OF CEMETERY OR CREMATORY  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE   |  |   |  |                                    |  |
| Burial  |  | 1/4/80  |  | King Mem. Pk.   |  | Baltimore Co., Md.   |  |   |  |                                    |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS  |  |   |  | 25a. DATE REC'D. BY REGISTRAR   |  | 25b. REGISTRAR'S SIGNATURE   |  |   |  |                                    |  |
| Wm C March F/H 1101 E. North Ave.   |  |   |  | DEC 31 1979   |  | <u>Patricia M. Brady</u>   |  |   |  |                                    |  |

ST P O O P I O C N U I

BY J O K A S T A

22 FEB 61

1 FEB 1961

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1b. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. GIVE PAGES 4 AND 5 TO THE CHIEF MEDICAL EXAMINER. GIVE PAGES 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100, 101, 102, 103, 104, 105, 106, 107, 108, 109, 110, 111, 112, 113, 114, 115, 116, 117, 118, 119, 120, 121, 122, 123, 124, 125, 126, 127, 128, 129, 130, 131, 132, 133, 134, 135, 136, 137, 138, 139, 140, 141, 142, 143, 144, 145, 146, 147, 148, 149, 150, 151, 152, 153, 154, 155, 156, 157, 158, 159, 160, 161, 162, 163, 164, 165, 166, 167, 168, 169, 170, 171, 172, 173, 174, 175, 176, 177, 178, 179, 180, 181, 182, 183, 184, 185, 186, 187, 188, 189, 190, 191, 192, 193, 194, 195, 196, 197, 198, 199, 200, 201, 202, 203, 204, 205, 206, 207, 208, 209, 210, 211, 212, 213, 214, 215, 216, 217, 218, 219, 220, 221, 222, 223, 224, 225, 226, 227, 228, 229, 230, 231, 232, 233, 234, 235, 236, 237, 238, 239, 240, 241, 242, 243, 244, 245, 246, 247, 248, 249, 250, 251, 252, 253, 254, 255, 256, 257, 258, 259, 260, 261, 262, 263, 264, 265, 266, 267, 268, 269, 270, 271, 272, 273, 274, 275, 276, 277, 278, 279, 280, 281, 282, 283, 284, 285, 286, 287, 288, 289, 290, 291, 292, 293, 294, 295, 296, 297, 298, 299, 300, 301, 302, 303, 304, 305, 306, 307, 308, 309, 310, 311, 312, 313, 314, 315, 316, 317, 318, 319, 320, 321, 322, 323, 324, 325, 326, 327, 328, 329, 330, 331, 332, 333, 334, 335, 336, 337, 338, 339, 340, 341, 342, 343, 344, 345, 346, 347, 348, 349, 350, 351, 352, 353, 354, 355, 356, 357, 358, 359, 360, 361, 362, 363, 364, 365, 366, 367, 368, 369, 370, 371, 372, 373, 374, 375, 376, 377, 378, 379, 380, 381, 382, 383, 384, 385, 386, 387, 388, 389, 390, 391, 392, 393, 394, 395, 396, 397, 398, 399, 400, 401, 402, 403, 404, 405, 406, 407, 408, 409, 410, 411, 412, 413, 414, 415, 416, 417, 418, 419, 420, 421, 422, 423, 424, 425, 426, 427, 428, 429, 430, 431, 432, 433, 434, 435, 436, 437, 438, 439, 440, 441, 442, 443, 444, 445, 446, 447, 448, 449, 450, 451, 452, 453, 454, 455, 456, 457, 458, 459, 460, 461, 462, 463, 464, 465, 466, 467, 468, 469, 470, 471, 472, 473, 474, 475, 476, 477, 478, 479, 480, 481, 482, 483, 484, 485, 486, 487, 488, 489, 490, 491, 492, 493, 494, 495, 496, 497, 498, 499, 500, 501, 502, 503, 504, 505, 506, 507, 508, 509, 510, 511, 512, 513, 514, 515, 516, 517, 518, 519, 520, 521, 522, 523, 524, 525, 526, 527, 528, 529, 530, 531, 532, 533, 534, 535, 536, 537, 538, 539, 540, 541, 542, 543, 544, 545, 546, 547, 548, 549, 550, 551, 552, 553, 554, 555, 556, 557, 558, 559, 560, 561, 562, 563, 564, 565, 566, 567, 568, 569, 570, 571, 572, 573, 574, 575, 576, 577, 578, 579, 580, 581, 582, 583, 584, 585, 586, 587, 588, 589, 590, 591, 592, 593, 594, 595, 596, 597, 598, 599, 600, 601, 602, 603, 604, 605, 606, 607, 608, 609, 610, 611, 612, 613, 614, 615, 616, 617, 618, 619, 620, 621, 622, 623, 624, 625, 626, 627, 628, 629, 630, 631, 632, 633, 634, 635, 636, 637, 638, 639, 640, 641, 642, 643, 644, 645, 646, 647, 648, 649, 650, 651, 652, 653, 654, 655, 656, 657, 658, 659, 660, 661, 662, 663, 664, 665, 666, 667, 668, 669, 670, 671, 672, 673, 674, 675, 676, 677, 678, 679, 680, 681, 682, 683, 684, 685, 686, 687, 688, 689, 690, 691, 692, 693, 694, 695, 696, 697, 698, 699, 700, 701, 702, 703, 704, 705, 706, 707, 708, 709, 710, 711, 712, 713, 714, 715, 716, 717, 718, 719, 720, 721, 722, 723, 724, 725, 726, 727, 728, 729, 730, 731, 732, 733, 734, 735, 736, 737, 738, 739, 740, 741, 742, 743, 744, 745, 746, 747, 748, 749, 750, 751, 752, 753, 754, 755, 756, 757, 758, 759, 760, 761, 762, 763, 764, 765, 766, 767, 768, 769, 770, 771, 772, 773, 774, 775, 776, 777, 778, 779, 780, 781, 782, 783, 784, 785, 786, 787, 788, 789, 790, 791, 792, 793, 794, 795, 796, 797, 798, 799, 800, 801, 802, 803, 804, 805, 806, 807, 808, 809, 810, 811, 812, 813, 814, 815, 816, 817, 818, 819, 820, 821, 822, 823, 824, 825, 826, 827, 828, 829, 830, 831, 832, 833, 834, 835, 836, 837, 838, 839, 840, 841, 842, 843, 844, 845, 846, 847, 848, 849, 850, 851, 852, 853, 854, 855, 856, 857, 858, 859, 860, 861, 862, 863, 864, 865, 866, 867, 868, 869, 870, 871, 872, 873, 874, 875, 876, 877, 878, 879, 880, 881, 882, 883, 884, 885, 886, 887, 888, 889, 890, 891, 892, 893, 894, 895, 896, 897, 898, 899, 900, 901, 902, 903, 904, 905, 906, 907, 908, 909, 910, 911, 912, 913, 914, 915, 916, 917, 918, 919, 920, 921, 922, 923, 924, 925, 926, 927, 928, 929, 930, 931, 932, 933, 934, 935, 936, 937, 938, 939, 940, 941, 942, 943, 944, 945, 946, 947, 948, 949, 950, 951, 952, 953, 954, 955, 956, 957, 958, 959, 960, 961, 962, 963, 964, 965, 966, 967, 968, 969, 970, 971, 972, 973, 974, 975, 976, 977, 978, 979, 980, 981, 982, 983, 984, 985, 986, 987, 988, 989, 990, 991, 992, 993, 994, 995, 996, 997, 998, 999, 1000.

FOR  
1- STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 30485

|  |  |   |   |   |                                   |   |                              |                                      |                      |
|--|--|---|---|---|-----------------------------------|---|------------------------------|--------------------------------------|----------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  | FIRST   | MIDDLE  | LAST  | 2a. DATE KNOWN OF DEATH           |   | 2b. DATE OF ESTI-MATED DEATH | 2c. DATE PRONOUNCED DEAD             | 2d. HOUR             |
| James C Page   |  |   |   |   | 12                                | 2   | 19                           | 79                                   | 4:00                 |
| 3. SEX   | 4. RACE  | 5. DATE OF BIRTH  | 6. AGE (IN YEARS)   | 7. IF UNDER 1 YR.   | 7. IF UNDER 24 HRS.               | 8. MARRIED  |                              | 9. BALTIMORE CITY OR COUNTY OF DEATH |                      |
| male   | black  | 12 1 35   | 44 YRS.   |   |                                   | NEVER MARRIED   |                              | Baltimore City                       |                      |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  | 7b. CITIZEN OF WHAT COUNTRY?                             |   | 8. MARRIED  |   | NEVER MARRIED                     |   | DIVORCED                     |                                      | MD.                  |
| Virginia   | USA  |   | WIDOWED   |   | DIVORCED                          |   |                              |                                      |                      |
| 10. CITY OR TOWN OF DEATH  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) |   | 12b. KIND OF BUSINESS OR INDUSTRY |   |                              |                                      |                      |
| Baltimore  | 1226 Argyle Avenue                                       |   |   |   |                                   |   |                              |                                      |                      |
| 13a. STATE   | 13b. COUNTY  | 13c. CITY OR TOWN   | 13d. INSIDE CITY LIMITS?                                      | 13e. STREET ADDRESS   |                                   |   |                              |                                      |                      |
| MD.  |  | Baltimore   | YES   | 1226 Argyle Avenue  |                                   |   |                              |                                      |                      |
| 14. FATHER'S NAME  | 15. MOTHER'S MAIDEN NAME                                 |   | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?                  |   | 16b. SOCIAL SECURITY NO.          |   | 17. INFORMANT                |                                      | ADDRESS              |
| Hamie  | Cora   |   | Yes   |   | 224-42-9689                       |   | Eva M. Page                  |                                      | 2713 Guilford Avenue |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |  |   |   |   |                                   |   |                              |                                      |                      |
| PART I DEATH WAS CAUSED BY: Hypertensive cardiovascular disease  |  |   |   |   |                                   |   |                              |                                      |                      |
| IMMEDIATE CAUSE (a): 4029  |  |   |   |   |                                   |   |                              |                                      |                      |
| DUE TO, OR AS A CONSEQUENCE OF   |  |   |   |   |                                   |   |                              |                                      |                      |
| (b):   |  |   |   |   |                                   |   |                              |                                      |                      |
| DUE TO, OR AS A CONSEQUENCE OF   |  |   |   |   |                                   |   |                              |                                      |                      |
| (c):   |  |   |   |   |                                   |   |                              |                                      |                      |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).  |  |   |   |   |                                   |   |                              |                                      |                      |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?           |   |   |                                   | 20. AUTOPSY?  |                              |                                      |                      |
|  |  |   |   |   |                                   | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                              |                                      |                      |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |  | 21b. TIME OF INJURY   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) |                                   |   |                              |                                      |                      |
|  |  | HOUR A.M. MONTH DAY YEAR                                    |   |   |                                   |   |                              |                                      |                      |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) |   | 21f. LOCATION   |                                   |   |                              |                                      |                      |
|  |  |   |   | CITY OR TOWN  |                                   | COUNTY  |                              | STATE                                |                      |
| (body only)  |  |   |   |   |                                   |   |                              |                                      |                      |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |  |   |   |   |                                   |   |                              |                                      |                      |
| ACTUAL SIGNATURE   |  | TITLE (SPECIFY)   |   |   |                                   | DATE SIGNED   |                              |                                      |                      |
| Hormez R. Guard, MD.   |  | Assistant   |   |   |                                   | 12/5/79   |                              |                                      |                      |
| EXAMINER'S NAME  |  | ADDRESS   |   |   |                                   |   |                              |                                      |                      |
| (TYPE OR PRINT)  |  | 111 Penn Street, Balto., MD 21201                           |   |   |                                   |   |                              |                                      |                      |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |  | 23b. DATE   | 23c. NAME OF CEMETERY OR CREMATORY                            |   | 23d. LOCATION                     |   |                              |                                      |                      |
| Burial   |  | 12/8/79   | King Memorial Park  |   | Randallstown, Maryland            |   |                              |                                      |                      |
| 24. FUNERAL DIRECTOR   |  | 25a. DATE REC'D. BY REGISTRAR                               |   | 25b. REGISTRAR'S SIGNATURE  |                                   |   |                              |                                      |                      |
| NAME   |  | ADDRESS   |   |   |                                   |   |                              |                                      |                      |
| Wm. C. March F.H./1101 E. North Ave.   |  | DEC 10 1979   |   | Rafaela M. Crady  |                                   |   |                              |                                      |                      |

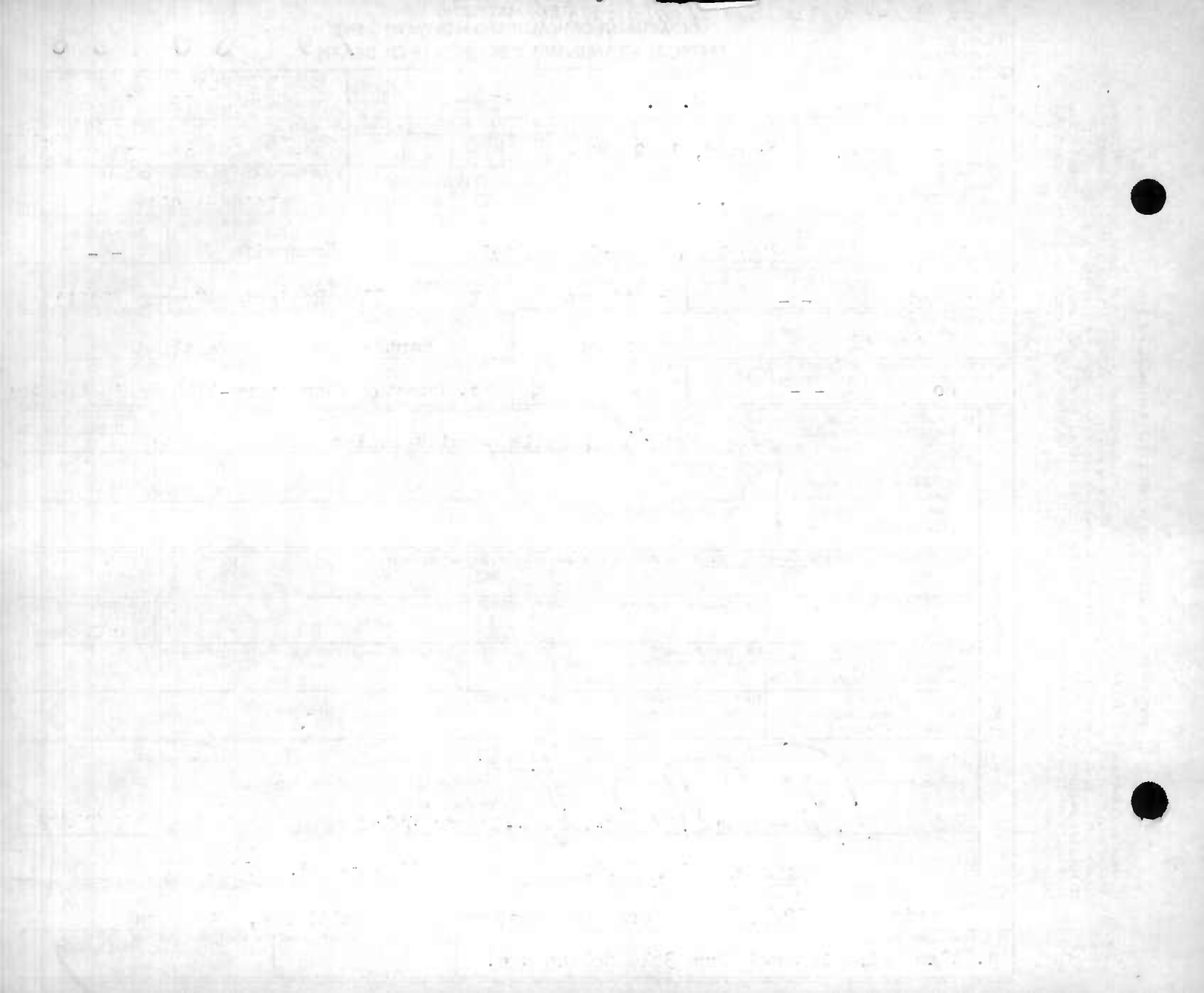


DEC 1 1950

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PA 3. RETAIN PAGE 5 WITH VITAL RECORDS. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED. WITHIN 48 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |  |                  |                   |   |                 |  |                |   |                                      | REG. NO. 30486  |             |   |           |   |            |   |                        |  |
|--|--|------------------|-------------------|---|-----------------|--|----------------|---|--------------------------------------|---|-------------|---|-----------|---|------------|---|------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  |                  | FIRST<br>Florence |   | MIDDLE<br>M. E. |  | LAST<br>Palmer |   | 2a. DATE KNOWN OF DEATH<br>ESTIMATED |   | MONTH<br>12 |   | DAY<br>21 |   | YEAR<br>79 |   | 2b. HOUR<br>M<br>9:10A |  |
| 3. SEX<br>Female   |  | 4. RACE<br>White |                   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>Sept 8, 1892  |                 | 6. AGE (IN YEARS LAST BIRTHDAY)<br>87 YRS.                             |                | IF UNDER 1 YR.<br>MONTHS DAYS   |                                      | IF UNDER 24 HRS.<br>HOURS MIN.                                    |             | 2c. DATE PRONOUNCED DEAD<br>MONTH DAY YEAR<br>12 21 79      |           | 2d. HOUR<br>M                             |            |   |                        |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland  |  |                  |                   | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A   |                 |  |                | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                                      |   |             | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City, MD. |           |   |            |   |                        |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore City  |  |                  |                   | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Maryland General Hospital |                 |  |                | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Housewife  |                                      |   |             | 12b. KIND OF BUSINESS OR INDUSTRY<br>--                     |           |   |            |   |                        |  |
| 13a. STATE<br>Maryland   |  |                  |                   | 13b. COUNTY<br>--   |                 | 13c. CITY OR TOWN<br>Baltimore   |                | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |                                      | 13e. STREET ADDRESS<br>3114 Remington Avenue (21211)              |             |   |           |   |            |   |                        |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Samuel Sunderland  |  |                  |                   |   |                 | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Martha Wantland       |                |   |                                      |   |             |   |           |   |            |   |                        |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br>No  |  |                  |                   | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>--   |                 | 17. INFORMANT<br>ADDRESS<br>Mrs. Dorothy Thornberry-3114 Remington Ave |                |   |                                      |   |             |   |           |   |            |   |                        |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>4292 IMMEDIATE CAUSE (a) Arteriosclerotic Cardiovascular Disease<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b) DUE TO, OR AS A CONSEQUENCE OF<br>(c)   |  |                  |                   |   |                 |  |                |   |                                      |   |             |   |           |   |            | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |                        |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).  |  |                  |                   |   |                 |  |                |   |                                      |   |             |   |           |   |            |   |                        |  |
| 19a. DATE OF OPERATION   |  |                  |                   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |                 |  |                |   |                                      |   |             |   |           |   |            | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                        |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |  |                  |                   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |                 |  |                | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |                                      |   |             |   |           |   |            |   |                        |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK  |  |                  |                   | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)   |                 |  |                | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |                                      |   |             |   |           |   |            |   |                        |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . |  |                  |                   |   |                 |  |                |   |                                      |   |             |   |           |   |            |   |                        |  |
| ACTUAL SIGNATURE<br>(TYPE OR PRINT)  |  |                  |                   | TITLE (SPECIFY)<br>Deputy Chief<br>MEDICAL EXAMINER   |                 |  |                |   |                                      |   |             |   |           | DATE SIGNED<br>12/21/79                   |            |   |                        |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT)   |  |                  |                   | Thomas D. Smith, M.D. ADDRESS 111 Penn St. Balto. Md  |                 |  |                |   |                                      |   |             |   |           |   |            |   |                        |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial   |  |                  |                   | 23b. DATE<br>12/24/79   |                 | 23c. NAME OF CEMETERY OR CREMATORY<br>Woodlawn Cemetery                |                |   |                                      | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore, Maryland |             |   |           |   |            |   |                        |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>A. Alan Seitz Funeral Home ADDRESS 3818 Roland Ave.  |  |                  |                   |   |                 |  |                |   |                                      | 25a. DATE REC'D. BY REGISTRAR<br>DEC 26 1979                      |             |   |           | 25b. REGISTRAR'S SIGNATURE<br>[Signature] |            |   |                        |  |







TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  |  |   |  |                                  |  |   | 7 9 3 0 4 8 7<br>REG. NO.   |  |  |  |
|---|--|---|--|--|---|--|----------------------------------|--|---|---|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT)<br>Baby Girl BRANDON M. PALMISANO  |  |   |  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br>12 20 79          |  |                                  | 2b. HOUR<br>5:58A <sup>M</sup>   |   |   |  |  |  |
| 3 SEX<br>FEMALE   |  | 4. RACE<br>WHITE  |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>12 18 77  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>— YRS.                                      |                                  | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.<br>2 48                                       |   | IF UNDER 24 HRS.  |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>USA  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD                      |                                  |  |   |   |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>BALTO CITY   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>UNIVERSITY HOSPITAL |  |  |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>INFANT        |                                  |  | 12b. KIND OF BUSINESS OR INDUSTRY   |   |  |  |  |
| 13a. STATE<br>Md.   |  |   |  |  | 13b. COUNTY<br>A.A. Co.                               |  | 13c. CITY OR TOWN<br>Glen Burnie |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |  | 13e. STREET ADDRESS<br>307 4th Ave. S.E. |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>THOMAS A PALMISANO   |  |   |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE<br>LAURA TOUREK |  |                                  |  |   |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>NO   |  | 16b. SOCIAL SECURITY NO.<br>none  |  | 17. INFORMANT ADDRESS Balto 21225<br>Mr. Allen Turek 123 Bon Air Ave.  |   |  |                                  |  |   |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) CARDIAC ARREST<br>769-<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>DUE TO, OR AS A CONSEQUENCE OF (b) ACUTE RENAL FAILURE<br>DUE TO, OR AS A CONSEQUENCE OF (c) SEVERE HYALINEMEMBRANES |  |   |  |  |   |  |                                  |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>6 HOURS<br>48 HOURS   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br>PREMATURITY   |  |   |  |  |   |  |                                  |  |   |   |  |  |  |
| 19a. DATE OF OPERATION  |  |   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   |  |                                  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>      |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |                                  |  |   |   |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK  |  |   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                 |                                  |  |   |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 12-18 19 79, to 12-20 19 79, that (I) (we) lost saw the deceased alive on 5:58AM 12-20 79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |   |  |  |   |  |                                  |  |   |   |  |  |  |
| 22b. SIGNATURE<br>Michael E. Moll MD  |  |   |  |  |   | DEGREE<br>MD   |                                  | 22c. DATE SIGNED<br>12-20-79   |   | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>MICHAEL E. MSALL   |  |   |  |  |   | 22e. ADDRESS<br>UNIV MD HOSP-DEPT PEDH   |                                  |  |   |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial   |  |   |  | 23b. DATE<br>12/21/79  |   | 23c. NAME OF CEMETERY OR CREMATORY<br>Cedar Hill Cemetery                      |                                  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br>Brooklyn A.A. Md.                         |   |   |  |  |  |
| 24. FUNERAL DIRECTOR NAME<br>George J. Gonce  |  |   |  |  |   | ADDRESS<br>Balto 21225<br>4001 Ritchie Hwy                                     |                                  | 25a. DATE REC'D. BY REGISTRAR<br>DEC 27 1979   |   | 25b. REGISTRAR'S SIGNATURE<br>P. J. Kelly   |  |  |  |

BP

DHMH - 16 25M

(VR A 15 (4) 9/74



M.E. Notified and Approved

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

7 9 3 0 4 8 8

1. FOR  
STATE  
REGISTRAR

|   |  |  |  |  |  |  |  |   |  |
|---|--|--|--|--|--|--|--|---|--|
| 1 DECEASED NAME<br>(TYPE OR PRINT) <b>Pete J. Panopoulos</b>  |  |  | 2a DATE OF DEATH<br>MONTH <b>12</b> DAY <b>24</b> YEAR <b>79</b>                             |  |  | 2b HOUR<br><b>11:07A</b>   |  |   |  |
| 3 SEX<br><b>MALE</b>  |  | 4 RACE<br><b>WHITE</b>   |  | 5 DATE OF BIRTH<br>MONTH <b>09</b> DAY <b>09</b> YEAR <b>11</b>  |  | 6 AGE [IN YEARS LAST BIRTHDAY]<br><b>68</b> YRS  |  | 7 IF UNDER 1 YEAR<br>MONTHS <b>00</b> DAYS <b>00</b> HOURS <b>00</b> MIN.   |  |
| 7a BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br><b>WASHINGTON, D.C.</b>  |  | 7b CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE, CITY</b> MD.  |  |   |  |
| 10 CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>  |  | 11 NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT KNOWN, GIVE ADDRESS)<br><b>3900 LOCH RAVEN BLVD., BALTO MD.</b> |  |  |  | 12a USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Truck Drive</b>  |  | 12b KIND OF BUSINESS OR INDUSTRY<br><b>Dist. Linen</b>  |  |
| 13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a STATE <b>Wash. D.C.</b>  |  |  | 13b COUNTY   |  | 13c CITY OR TOWN   |  | 13d INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   |  |
| 14 FATHER'S NAME<br>FIRST <b>James</b> MIDDLE <b>R.</b> LAST <b>Panopoulos</b>  |  |  | 15 MOTHER'S MAIDEN NAME<br>FIRST <b>Vasiliki</b> MIDDLE <b>Margelos</b> LAST <b>Margelos</b> |  |  |  |  |   |  |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>Yes</b>   |  |  | 16b SOCIAL SECURITY NO.<br><b>W.W.11 578-09-0962</b>   |  | 17 INFORMANT (Sister)<br><b>Sophia P. Maroulis</b>                                   |  | ADDRESS<br><b>3108-0-St.S.E. Wash.D.C.</b>   |   |  |
| 18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <b>Bronchial pneumonia</b><br><b>485-</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____ |  |  |  |  |  |  |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| 19a DATE OF OPERATION   |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  | 20a AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. <b>19</b>                            |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)       |  |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                       |  | 21f. LOCATION<br>CITY OR TOWN <b>Washington</b> COUNTY <b>D.C.</b> STATE <b>M.D.</b> |  |  |   |  |
| 22a. I certify that (this hospital) attended the deceased from <b>12-24</b> , 19 <b>79</b> , to <b>12-24</b> , 19 <b>79</b> , that (we) last saw the deceased alive on <b>12-24</b> , 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (We) (I) did not view the body after death.   |  |  |  |  |  |  |  |   |  |
| 22b. SIGNATURE<br><b>Kristen B. Raines</b>  |  |  | DEGREE<br><b>MD</b>  |  |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br><b>12/25/79</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Kristen B. Raines MD</b>  |  |  | 22e. ADDRESS<br><b>3900-Loch Raven Blvd. Baltimore, Md.</b>                                  |  |  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>  |  |  | 23b. DATE<br><b>12/28/79</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Glenwood Cemetery</b>                       |  | 23d. LOCATION<br>CITY OR TOWN <b>Washington</b> COUNTY <b>D.C.</b> STATE <b>M.D.</b>           |   |  |
| 24. FUNERAL DIRECTOR<br>NAME <b>Hines/Rinaldi F.H.</b> ADDRESS <b>11800-New Hampshire Ave. Silver Spring, Md.</b>   |  |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>DEC 28 1979</b>                                  |  | 25b. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>   |   |  |



Form 100-1

1

WHITE

2

100-100-100

100-100-100

100-100-100

100-100-100

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(100-100-100)

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100-100-100

100-100-100

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |   |  |  |  |  |  |   |   |
|---|--|---|--|--|--|--|--|---|---|
| 1- FOR STATE REGISTRAR  |  |   |  |  | 7 9 3 0 4 8 9  |  |  |   |   |
| 1 DECEASED NAME (TYPE OR PRINT)   |  |   |  |  | 2a DATE OF DEATH   |  |  |   |   |
| FIRST MIDDLE LAST<br>LED J PAREMSKE, SR.  |  |   |  |  | MONTH DAY YEAR<br>12 17 79   |  |  |   |   |
| 3 SEX<br>Male   |  | 4 RACE<br>White   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>12 20 04   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>74 YRS.   |  | 2b HOUR<br>5:30 A M                         |   |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Lithuania   |  | 7b CITIZEN OF WHAT COUNTRY?<br>USA  |  | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.                                     |  |   |   |
| 10. CITY OR TOWN OF DEATH<br>Baltimore  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>South Baltimore General Hosp. |  |  |  | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Chemical Worker                |  | 12b KIND OF BUSINESS OR INDUSTRY<br>Retired |   |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |   |  |  | 13d INSIDE CITY LIMITS?  |  |  |   |   |
| 13a STATE<br>MD   |  | 13b COUNTY<br>-----   |  | 13c CITY OR TOWN<br>Baltimore  |  | 13d INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e STREET ADDRESS<br>1624 Plum St.         |   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Julian J. PAREMSKI  |  |   |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Axevena Kneves                      |  |  |   |   |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>NO  |  | 16b SOCIAL SECURITY NO.<br>217-03-8664  |  | 17. INFORMANT ADDRESS<br>WANDA PAREMSKI Same as above.   |  |  |  |   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a): Respiratory depression, Cardiac Arrest.<br>436-<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) pneumonia, septicemia CHF<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) Cerebrovascular Accident<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>7 days<br>7 days |  |   |  |  |  |  |  |   | PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |  |  |   |   |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |  |  |   |   |
| 22a. I certify that (I) (this hospital) attended the deceased from 12/10 19 79 to 12/17 19 79, that (I) (we) last saw the deceased alive on 12/17 19 79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |   |  |  |  |  |  |   |   |
| 22b. SIGNATURE<br>DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>   |  |   |  |  | 22c. DATE SIGNED   |  |  |   |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Myung Jin Lim  |  |   |  |  | 22e. ADDRESS<br>South Baltimore General Hosp.  |  |  |   |   |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial   |  | 23b. DATE<br>12/20/79   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Holy Cross Cemetery  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore Anne Arundel Md.                       |  |   |   |
| 24. FUNERAL DIRECTOR<br>NAME<br>Mc Cully Funeral Home of Baltimore<br>4200 Pennington Avenue  |  |   |  |  | 25a. DATE REC'D. BY REGISTRAR<br>DEC 17 1979   |  | 25b. REGISTRAR'S SIGNATURE<br>Rifky, K. Brady  |   |   |

1917  
JAN 10  
1917

TO THE DIRECTOR  
BUREAU OF PLANT INDUSTRY  
WASHINGTON, D. C.

FROM THE  
DIRECTOR  
BUREAU OF PLANT INDUSTRY  
WASHINGTON, D. C.

SUBJECT  
PLANT INDUSTRY  
WASHINGTON, D. C.

PLANT INDUSTRY  
WASHINGTON, D. C.

PLANT INDUSTRY  
WASHINGTON, D. C.

PLANT INDUSTRY  
WASHINGTON, D. C.

PLANT INDUSTRY  
WASHINGTON, D. C.

PLANT INDUSTRY  
WASHINGTON, D. C.

PLANT INDUSTRY  
WASHINGTON, D. C.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

1- FOR  
STATE  
REGISTRAR

REG. NO.

|   |  |   |  |   |  |  |  |
|---|--|---|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |  | FIRST MIDDLE LAST<br>ELIZABETH C. PARLETT   |  | 2a. DATE OF DEATH MONTH DAY YEAR<br>12 5 79   |  | 2b. HOUR<br>7:20 P.M.  |  |
| 3 SEX<br>Female   |  | 4. RACE<br>White  |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>Nov 21, 1914   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>65 YRS.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Virginia   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City, MD.  |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Good Samaritan Hospital. |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Bookkeeper  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Religious Store   |  |
| 13a. STATE<br>Maryland  |  | 13b. COUNTY<br>Baltimore  |  | 13c. CITY OR TOWN<br>Baynesville  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                            |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>-- -- Callahan   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Julia Dabney  |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>No  |  |  |  |
| 16b. SOCIAL SECURITY NO.<br>212 -03 -1419   |  | 17. INFORMANT ADDRESS<br>George J. Parlett 8701 Littlewood Rd. 21234  |  |   |  |  |  |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>CARDIO-PULMONARY FAILURE</u><br>1629<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>METASTATIC ADENOCARCINOMA OF LUNG.</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>---</u> |  |   |  |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>11/23</u> 19 <u>79</u> to <u>12/5</u> 19 <u>79</u> , that (I) (we) last saw the deceased alive on <u>12/5</u> 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not view the body after death).   |  |   |  |   |  |  |  |
| 22b. SIGNATURE<br>H. S. Sonara MD   |  | DEGREE  |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                  |  | 22c. DATE SIGNED<br>12/7/79  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>H. S. SONARA.  |  | 22e. ADDRESS<br>GOOD SAMARITAN HOSPITAL.  |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial   |  | 23b. DATE<br>Dec 10, 79   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Dulaney Valley Park   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Cockeysville, Balto Co., Md.   |  |
| 24. FUNERAL DIRECTOR NAME<br>Dippel Brothers Inc.   |  | 7710 Belair Road  |  | 25a. DATE REC'D. BY REGISTRAR<br>DEC 7 1979   |  | 25b. REGISTRAR'S SIGNATURE<br>[Signature]  |  |

BP





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  |  |  |                                      |  |  |  | 7 9 3 0 4 9 1  |     |   |          |   |  |
|---|--|--|--|--|--|--------------------------------------|--|--|--|--|-----|---|----------|---|--|
| 1. FOR STATE REGISTRAR  |  | REG. NO.   |  |  |  |                                      |  |  |  |  |     |   |          |   |  |
| 1. DECEASED NAME (TYPE OR PRINT)  |  | FIRST  |  | MIDDLE   |  | LAST                                 |  | 2a. DATE OF DEATH  |  | MONTH  | DAY | YEAR  | 2b. HOUR |   |  |
| Henry   |  | None   |  | Parrish  |  | 12/10/79                             |  | 2  |  | P.M.   |     |   |          |   |  |
| 3. SEX  |  | 4. RACE  |  | 5. DATE OF BIRTH   |  | 6. AGE (IN YEARS LAST BIRTHDAY)      |  | IF UNDER 1 YEAR  |  | IF UNDER 24 HRS  |     |   |          |   |  |
| MALE  |  | White  |  | 2 17 03  |  | 76 YRS                               |  | MONTHS   |  | DAYS   |     | HOURS MIN.  |          |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH |  |  |  |  |     |   |          |   |  |
| Maryland  |  | U.S.   |  |  |  | BALTO. MD.                           |  |  |  |  |     |   |          |   |  |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |  |  |                                      |  |  |  |  |     | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) |          | 12b. KIND OF BUSINESS OR INDUSTRY                                   |  |
| BALTO   |  | Key Circle Hospice   |  |  |  |                                      |  |  |  |  |     |   |          |   |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |  |  |  |  |                                      |  |  |  | 13d. INSIDE CITY LIMITS?                                       |     |   |          | 13e. STREET ADDRESS   |  |
| 13a. STATE  |  |  |  |  |  |                                      |  |  |  | 13b. COUNTY  |     | 13c. CITY OR TOWN   |          | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| MD  |  |  |  |  |  |                                      |  |  |  | BALTO  |     | 1723 St. Paul Street  |          |   |  |
| 14. FATHER'S NAME   |  |  |  |  | 15. MOTHER'S MAIDEN NAME                             |                                      |  |  |  |  |     |   |          |   |  |
| FIRST MIDDLE LAST   |  |  |  |  | FIRST MIDDLE LAST                                    |                                      |  |  |  |  |     |   |          |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)   |  |  |  |  | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) |                                      |  |  |  | 17. INFORMANT ADDRESS  |     |   |          |   |  |
|   |  |  |  |  | 242-16-007   |                                      |  |  |  | Key Circle Hospice 1214 Eutaw Pl.                              |     |   |          |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |  |  |  |  |  |                                      |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                   |     |   |          |   |  |
| PART I. DEATH WAS CAUSED BY:  |  |  |  |  |  |                                      |  |  |  |  |     |   |          |   |  |
| IMMEDIATE CAUSE (a) Lung Cancer   |  |  |  |  |  |                                      |  |  |  | several weeks  |     |   |          |   |  |
| 1629  |  |  |  |  |  |                                      |  |  |  |  |     |   |          |   |  |
| DUE TO, OR AS A CONSEQUENCE OF  |  |  |  |  |  |                                      |  |  |  |  |     |   |          |   |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.  |  |  |  |  |  |                                      |  |  |  |  |     |   |          |   |  |
| DUE TO, OR AS A CONSEQUENCE OF  |  |  |  |  |  |                                      |  |  |  |  |     |   |          |   |  |
| (c)   |  |  |  |  |  |                                      |  |  |  |  |     |   |          |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |  |  |  |  |                                      |  |  |  |  |     |   |          |   |  |
| U.T.I. & CHF several weeks  |  |  |  |  |  |                                      |  |  |  |  |     |   |          |   |  |
| 19a. DATE OF OPERATION  |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |                                      |  | 20a. AUTOPSY?  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |     |   |          |   |  |
|   |  |  |  |  |  |                                      |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | YES <input type="checkbox"/> NO <input type="checkbox"/>       |     |   |          |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR   |  |                                      |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |  |     |   |          |   |  |
|   |  |  |  | P.M. 19  |  |                                      |  |  |  |  |     |   |          |   |  |
| 21d. INJURY OCCURRED  |  |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  |                                      |  | 21f. LOCATION  |  |  |     |   |          |   |  |
| WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |  |  |  |  |                                      |  | STREET CITY OR TOWN COUNTY STATE   |  |  |     |   |          |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 11: 8, 19 79, to 11: 10, 19 79, that (I) (we) last saw the deceased alive on 12: 10, 19 79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |                                      |  |  |  |  |     |   |          |   |  |
| 22b. SIGNATURE  |  |  |  |  |  |                                      |  | DEGREE   |  | 22c. DATE SIGNED   |     |   |          |   |  |
| E. Ellsworth Cook MD  |  |  |  |  |  |                                      |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 12. 11. 79   |     |   |          |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  |  |  |  |  |                                      |  | 22e. ADDRESS   |  |  |     |   |          |   |  |
| E. Ellsworth Cook   |  |  |  |  |  |                                      |  | 2431 Maryland Ave.   |  |  |     |   |          |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   |  |  |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY   |  |  |  | 23d. LOCATION  |     |   |          |   |  |
| Cremation   |  |  |  | 12/17/79   |  | Westview                             |  |  |  | Catonville COUNTY STATE  |     |   |          |   |  |
| 24. FUNERAL DIRECTOR  |  |  |  |  |  |                                      |  | 25a. DATE REC'D. BY REGISTRAR  |  | 25b. REGISTRAR'S SIGNATURE                                     |     |   |          |   |  |
| NAME Charles A. Rice 1300 Eutaw Place ADDRESS   |  |  |  |  |  |                                      |  | DEC 17 1979  |  | D. J. Kelly  |     |   |          |   |  |



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BP

DHMH - 16 50M 1/76  
(VR A 15 (4))

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

7 9 3 0 4 9 2

1 - FOR  
STATE  
REGISTRAR

REG. NO.

|   |  |  |  |  |  |  |   |  |  |
|---|--|--|--|--|--|--|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>LE ROY Wm PARRISH</b>  |  |  | 2a. DATE OF DEATH<br>MONTH <b>DEC</b> DAY <b>13</b> YEAR <b>79</b>     |  |  | 2b. HOUR<br><b>1:10 P.M.</b>   |   |  |  |
| 3 SEX<br><b>M</b>   |  | 4 RACE<br><b>W</b>   |  | 5. DATE OF BIRTH<br>MONTH <b>05</b> DAY <b>03</b> YEAR <b>25</b>   |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br><b>54</b> YRS  |   | IF UNDER 1 YEAR<br>MONTHS <b></b> DAYS <b></b> HOURS <b></b> MIN. <b></b>  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTO CITY</b> MD.   |   |  |  |
| 10 CITY OR TOWN OF DEATH<br><b>BALTO</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>SINAI Hospital</b> |  |  |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Maintenance man Cap Factory</b> |   | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| 13a. STATE<br><b>MD</b>   |  |  | 13b. CITY OR TOWN<br><b>BALTO.</b>                                     |  | 13c. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  | 13d. STREET ADDRESS<br><b>123 PITTSFORD CIRCLE</b>                        |  |  |
| 14 FATHER'S NAME<br>FIRST <b>Walter</b> MIDDLE <b>Clay</b> LAST <b>Parrish</b>  |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>Ethel</b> MIDDLE <b>Boyle</b> LAST <b>Boyle</b>   |  |  |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>   |  |  |  | 16b. SOCIAL SECURITY NO.<br><b>218-14-7789</b>   |  | 17 INFORMANT<br>ADDRESS<br><b>HOSPITAL CHART</b>   |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>METASTATIC SQUAMOUS CELL CANCER</b><br><b>1629</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>OF LUNG</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(c) <b></b>   |  |  |  |  |  |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):  |  |  |  |  |  |  |   |  |  |
| 19a. DATE OF OPERATION  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                   |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>      |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)       |  |   |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |  |   |  |  |
| 22a. I certify that (I <del>person</del> ) attended the deceased from <b>12/17</b> , 19 <b>79</b> , to <b>12/13</b> , 19 <b>79</b> , that (I <del>person</del> ) lost saw the deceased alive on <b>12/12</b> , 19 <b>79</b> , and that in (my <del>person</del> ) opinion death occurred on the date and hour and from the causes stated above, (I <del>person</del> ) (did) (did not) view the body after death. |  |  |  |  |  |  |   |  |  |
| 22b. SIGNATURE<br><b>Meyer R. Heyman M.D.</b>   |  |  |  |  |  | DEGREE<br><b>M.D.</b>  |   | 22c. DATE SIGNED<br><b>12/13/79</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>MEYER R. HEYMAN M.D.</b>  |  |  |  |  |  | 22e. ADDRESS<br><b>13ALTO. MD. 21215</b><br><b>2435 W. BELVEDERE AVE</b>                               |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>BURIAL</b>   |  |  | 23b. DATE<br><b>Dec. 17, 1979</b>                                      |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Evergreen Mem. Gar</b>                      |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Finksburg Carroll Md</b> |  |  |
| 24. FUNERAL DIRECTOR<br>NAME <b>A. G. Schmitt</b> ADDRESS <b>Owings Mills, Md.</b>  |  |  |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>DEC 17 1979</b>  |   | 25b. REGISTRAR'S SIGNATURE<br><b>R. Schmitt</b>  |  |

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| 1. FOR STATE REGISTRAR   |  | STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |   | 7 9 3 0 4 9 3<br>REG. NO.   |  |
|--|--|---|---|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>TERRY Ronald PARRISH</b>   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>DECEMBER 29, 1979</b>   |   | 2b. HOUR<br><b>8:45 AM</b>  |  |
| 3. SEX<br><b>Male</b>  | 4. RACE<br><b>White</b>  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>April 28, 1942</b>   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>37</b> YRS.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>North Carolina</b>   | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.                               |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>THE JOHNS HOPKINS HOSPITAL</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>TRUCK DRIVER</b> |   | 12b. KIND OF BUSINESS OR INDUSTRY            |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>North Carolina</b>  |  | 13b. COUNTY<br><b>Thomasville</b>   |   | 13c. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>? Parrish</b>   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Rilla May ?</b>   |   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>243-66-3896</b>  |   | 17. INFORMANT<br>ADDRESS<br><b>Mrs Alice H Parrish Same</b>                                     |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <b>Cardiac Pulmonary Arrest.</b><br><b>2041</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) <b>Interlobar Pneumonia</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Chronic Myelocytic Leukemia, Spl Bone Marrow Transplant.</b> |  |   |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)  |  |   |   |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>            |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>19</b>  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)                  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost<br>saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.  |  |   |   |   |  |
| 22b. SIGNATURE<br><b>Ernest Barbosa</b>  |  | DEGREE<br><b>M.D.</b>   |   | 22c. DATE SIGNED<br><b>12/29/79</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Ernest Barbosa</b>   |  | 22e. ADDRESS<br><b>Johns Hopkins Hospital, Baltimore-MD</b>   |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>/Burial</b>   |  | 23b. DATE<br><b>1/2/80</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Holly Hill</b>   |  |
| 23d. LOCATION<br>CITY OR TOWN<br><b>Davidson County</b>  |  | COUNTY<br><b>N.C.</b>   |   | STATE   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Leonard Jruck Inc. Baltimore, Maryland</b>  |  | ADDRESS   |   | 25a. DATE REC'D. BY REGISTRAR<br><b>DEC 31 1979</b>   |  |
|  |  |   |   | 25b. REGISTRAR'S SIGNATURE<br><b>Anthony McCreedy</b>   |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |                 |  |  |   |  |
|--|-----------------|--|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>SOPHIA PATTERSON   |                 | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>12 5 1979   |  | 2b. HOUR<br>3:30 PM   |  |
| 3 SEX<br>Female  | 4 RACE<br>BLACK | 5 DATE OF BIRTH<br>MONTH DAY YEAR<br>7 02 05   |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br>74 YRS  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>N.C.  |                 | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |  |
| 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD  |                 | 10 CITY OR TOWN OF DEATH<br>BALTIMORE  |  |   |  |
| 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Poplar Manor 3013 Poplar St 21216   |                 | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)   |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |
| 13a. STATE<br>MARYLAND   |                 | 13b. COUNTY<br>BALTIMORE   |  | 13c. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br>James Wadsworth   |                 | 15 MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Dillia Harrington  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>NO   |                 | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>215-12-5802   |  | 17 INFORMANT<br>ADDRESS<br>Regina Taylor 2238 Madison Ave.  |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) 1539<br>DUE TO, OR AS A CONSEQUENCE OF (b) CANCER OF COLON. with Metastases<br>DUE TO, OR AS A CONSEQUENCE OF (c)   |                 |  |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a):  |                 |  |  |   |  |
| 19a. DATE OF OPERATION   |                 | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |                 | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |                 | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 11:23 to 12:5, 1979, that (I) (we) last saw the deceased alive on 12/5/79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |                 |  |  |   |  |
| 22b. SIGNATURE<br>[Signature]  |                 | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br>12/5/79   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Arbutus L. Suresky  |                 | 22e. ADDRESS<br>5010 - York Rd Baltimore   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial   |                 | 23b. DATE<br>12/8/79   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Arbutus Mem. Pk.  |  |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Arbutus, Md.   |                 | 23e. DATE REC'D. BY REGISTRAR<br>DEC 10 1979   |  |   |  |
| 24 FUNERAL DIRECTOR<br>NAME<br>Wm C March F/H  |                 | 24b. ADDRESS<br>1101 E. North Ave.   |  |   |  |

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DEC 10 1973





FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

7 9 3 0 4 9 5  
REG. NO.

|  |  |  |  |  |   |  |   |   |  |
|--|--|--|--|--|---|--|---|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>HAROLD PATZ</b>  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>DECEMBER 18 1979</b> |  |   | 2b. HOUR<br><b>7:06 PM</b>   |   |   |  |
| 3. SEX<br><b>MALE</b>  |  | 4. RACE<br><b>WHITE</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>JUNE 19, 1906</b>   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>73</b> YRS.  |   | 7. IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.  |  |
| 7a. BIRTHPLACE (CITY OR TOWN, COUNTY)<br><b>BEAUFORT, S. CAROLINA</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>    |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.                          |   |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>JOHNS HOPKINS HOSPITAL</b> |  |  |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>PROJECT MANAGER</b> |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>REAL ESTATE</b>   |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>MARYLAND</b>   |  |  | 13b. COUNTY<br><b>BALTIMORE</b>                                |  | 13c. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13d. STREET ADDRESS<br><b>APT. 208 5715 PARK HTS. AVE. #21215</b> |   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>BENJAMIN L. PATZ</b>  |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>YETTA FLEISHMAN</b>  |   |  |   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>217-09-2509</b>  |  | 17. INFORMANT<br><b>NATHAN PATZ</b> ADDRESS<br><b>2110 MARYLAND NATIONAL BANK BLDG. BALTO., MD 21202</b>   |   |  |   |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>cardio-pulmonary arrest</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br><b>5119 hypoxia and asphyxia</b><br>DUE TO, OR AS A CONSEQUENCE OF<br><b>renal &amp; peritoneal effusions</b> |  |  |  |  |   |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>5 minutes</b><br><b>12 hrs</b><br><b>7 days</b>                                    |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><b>metastatic adenocarcinoma</b>  |  |  |  |  |   |  |   |   |  |
| 19a. DATE OF OPERATION<br><b>Dec 4 1979</b>  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>metastatic adenocarcinoma</b>   |  |  |   | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>       |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |   |  |   |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |   |  |   |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>Dec 4 1979</b> to <b>Dec 18 1979</b> , that (I) (we) last saw the deceased alive on <b>Dec 18 7:06 PM 1979</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.  |  |  |  |  |   |  |   |   |  |
| 22b. SIGNATURE<br><b>Peter Rock</b>  |  |  |  | DEGREE<br><b>MD</b> ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |   |  |   | 22c. DATE SIGNED<br><b>12-18-79</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Peter Rock</b>   |  |  |  | 22e. ADDRESS<br><b>Johns Hopkins Hospital</b>  |   |  |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>BURIAL</b>   |  | 23b. DATE<br><b>DEC. 20, 1979</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>BETH TFILOH</b>   |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>BALTIMORE MARYLAND</b>                    |   | 23e. DATE REC'D. BY REGISTRAR<br><b>DEC 27 1979</b>   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>SOL LEVINSON &amp; BROS., INC.</b>  |  |  |  | 25. ADDRESS<br><b>6010 REISTERSTOWN RD. BALTO., MD 21215</b>   |   |  |   |   |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 27 calendar days with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of this.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  |   |  |  |  |                        |  |
|--|--|--|--|---|--|--|--|------------------------|--|
| 1. FOR STATE REGISTRAR   |  | 7 9 3 0 4 9 6  |  | REG. NO.  |  |  |  |                        |  |
| 1. DECEASED NAME (TYPE OR PRINT)   |  | FIRST MIDDLE LAST  |  | 2a. DATE OF DEATH MONTH DAY YEAR  |  | 2b. HOUR   |  |                        |  |
| A. Elizabeth Paulus  |  |  |  | 12/3/79   |  | M  |  |                        |  |
| 3. SEX   |  | 4. RACE  |  | 5. DATE OF BIRTH MONTH DAY YEAR   |  | 6. AGE (IN YEARS LAST BIRTHDAY)                                |  | 7. IF UNDER 1 YEAR     |  |
| Female   |  | White  |  | 4/23/95   |  | 84 YRS.  |  | MONTHS DAYS HOURS MIN. |  |
| 8. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  | 9. CITIZEN OF WHAT COUNTRY?  |  | 10. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 11. BALTIMORE CITY OR COUNTY OF DEATH                          |  |                        |  |
| Balto City   |  | USA  |  |   |  | Baltimore City   |  |                        |  |
| 12. CITY OR TOWN OF DEATH  |  | 13. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 14. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |  | 15. KIND OF BUSINESS OR INDUSTRY                               |  |                        |  |
| Balto.   |  | St. Agnes Hopt.  |  | Secy. Rowan Controller Co.  |  |  |  |                        |  |
| 16. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  | 17. INSIDE CITY LIMITS?  |  | 18. STREET ADDRESS  |  |  |  |                        |  |
| 13a. STATE 13b. COUNTY   |  | 13c. CITY OR TOWN  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 323 Register Avenue  |  |                        |  |
| Md. Balto.   |  | Rodgers Forge  |  |   |  |  |  |                        |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST   |  |   |  |  |  |                        |  |
| John J. Paulus   |  | Mary A. Dumler   |  |   |  |  |  |                        |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)  |  | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT ADDRESS   |  |  |  |                        |  |
| No   |  | 213-14-5280  |  | Mr. John N. Paulus-323 Register Avenue 12   |  |  |  |                        |  |
| 11. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY.  |  |  |  |   |  |  |  |                        |  |
| IMMEDIATE CAUSE (a) massive cerebral infarct on thrombosis   |  |  |  |   |  |  |  |                        |  |
| 4148   |  |  |  |   |  |  |  |                        |  |
| DUE TO, OR AS A CONSEQUENCE OF (b) ASCVD   |  |  |  |   |  |  |  |                        |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.   |  |  |  |   |  |  |  |                        |  |
| DUE TO, OR AS A CONSEQUENCE OF (c)   |  |  |  |   |  |  |  |                        |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |  |  |   |  |  |  |                        |  |
| atrial fibrillation, myocardial ischemia   |  |  |  |   |  |  |  |                        |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |  |                        |  |
|  |  |  |  | YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | YES <input type="checkbox"/> NO <input type="checkbox"/>       |  |                        |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |                        |  |
|  |  | P.M. 19  |  |   |  |  |  |                        |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  | 21f. LOCATION STREET  |  | CITY OR TOWN   |  | COUNTY STATE           |  |
|  |  |  |  |   |  |  |  |                        |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 11-30, 1979, to 12-3, 1979, that (I) (we) lost the deceased alive on 12-3, 1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) not view the body after death. |  |  |  |   |  |  |  |                        |  |
| 22b. SIGNATURE   |  | DEGREE   |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>                |  | 22c. DATE SIGNED   |  |                        |  |
| Bruce R. McGurdy M.D.  |  |  |  |   |  | 12-3-79  |  |                        |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  | 22e. ADDRESS   |  |   |  |  |  |                        |  |
| Dr. Bruce McGurdy  |  | 900 S. Caton Ave. Balto. Md. 21229   |  |   |  |  |  |                        |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY  |  | 23d. LOCATION CITY OR TOWN                                     |  | COUNTY STATE           |  |
| Burial   |  | 12/7/79  |  | Holy Redeemer Cem.  |  | Balto City   |  |                        |  |
| 24. FUNERAL DIRECTOR NAME  |  | 24b. ADDRESS   |  | 25a. DATE REC'D. BY REGISTRAR   |  | 25b. REGISTRAR'S SIGNATURE                                     |  |                        |  |
| Mitchell-Wiedefeld Home  |  | 6500 York Rd. 21212  |  | DEC 11 1979   |  | L. McGurdy   |  |                        |  |

subject is *Trachypogon* *darwini* *darwini*  
7/20/06

as seen in *Trachypogon* *darwini* *darwini*

from *Trachypogon* *darwini* *darwini*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  |   |  |   |  |   |                    | 7 9 3 0 4 9 7<br>REG. NO.  |  |
|--|--|--|--|---|--|---|--|---|--------------------|--|--|
| 1. FOR STATE REGISTRAR   |  | 1. DECEASED NAME (TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>JESSIE FRANKLIN PEARL   |  |   |  | 2a. DATE OF DEATH MONTH DAY YEAR<br>12 27 79  |  |   | 2b. HOUR<br>6:55 A |  |  |
| 3 SEX<br>M   |  | 4 RACE<br>W  |  | 5 DATE OF BIRTH MONTH DAY YEAR<br>5 31 04   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>75 YRS.  |  | IF UNDER 1 YEAR MONTHS DAYS   |                    | IF UNDER 24 HRS. HOURS MIN.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>BALTIMORE   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD.                                      |  |   |                    |  |  |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>SAINT AGNES HOSPITAL |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>MAINTENANCE                    |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>WARDS MONTGOMERY   |                    |  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>MARYLAND   |  | 13b. COUNTY<br>---   |  | 13c. CITY OR TOWN<br>BALTIMORE  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br>2627 GEORGETOWN RD. 21230  |                    |  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>FRANKLIN J. PEARL   |  |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>MARY M. HANN  |  |   |  |   |                    |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>NO  |  | 16b. SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES)<br>---   |  | 17. INFORMANT<br>430 2nd. Ave. East<br>North Port, N.Y. 11731<br>GEORGE E. DUNN   |  |   |  |   |                    |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>HYPOXIA</u><br><u>4275</u><br>DUE TO, OR AS A CONSEQUENCE OF (b) <u>CARDIO RESPIRATORY ARREST</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>DUE TO, OR AS A CONSEQUENCE OF (c) <u>BRAINSTEM INFARCT</u> |  |  |  |   |  |   |  |   |                    | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>12/20/79</u><br><u>12/27/79</u> |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):<br><u>POSSIBLE SEPSIS</u>   |  |  |  |   |  |   |  |   |                    |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                    |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |   |                    |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |   |  |   |                    |  |  |
| 22a. I certify that <del>this</del> (this hospital) attended the deceased from <u>12/20</u> , 19 <u>79</u> , to <u>12/27</u> , 19 <u>79</u> , that <del>the</del> most saw the deceased alive on <u>12/26</u> , 19 <u>79</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above (we) (did) not view the body after death.                         |  |  |  |   |  |   |  |   |                    |  |  |
| 22b. SIGNATURE<br><u>Steven H. Tucker, M.D.</u>  |  |  |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>        |  |   |  | 22c. DATE SIGNED<br><u>12/27/79</u>   |                    |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><u>TUCKER, M. D.</u>  |  |  |  | 22e. ADDRESS<br>900 S CATON AVE BALTO MD 21229  |  |   |  |   |                    |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>BURIAL  |  | 23b. DATE<br>12/29/79  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>MEADOWRIDGE MEM. PK.  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br>ELKDRIDGE HOWARD MD.                                 |  |   |                    |  |  |
| 24. FUNERAL DIRECTOR NAME<br>HUBBARD FUNERAL HOME  |  |  |  | ADDRESS<br>4107 WILKENS AVE. 21229  |  | 25a. DATE REC'D. BY REGISTRAR<br>DEC 28 1979  |  | 25b. REGISTRAR'S SIGNATURE<br><u>Ruby McCreedy</u>  |                    |  |  |

BP

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BALTIMORE CITY

STATION STREET HOSPITAL

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH-17  
(VR A15 ME (5))  
30M 7/73

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 30498

|   |  |  |  |  |  |   |  |  |  |                         |  |   |  |
|---|--|--|--|--|--|---|--|--|--|-------------------------|--|---|--|
| FOR<br>1- STATE<br>REGISTRAR  |  | DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH |  |  |  |   |  |  |  |                         |  | REG. NO. 30498  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |  |  |  |  |  | 2a. DATE KNOWN OF DEATH   |  |  |  |                         |  | 2b. HOUR  |  |
| Michael A. Pearson  |  |  |  |  |  | ESTIMATED MONTH DAY YEAR 12 21 1979                                 |  |  |  |                         |  | 6:08 P.M.   |  |
| 3. SEX  |  | 4. RACE  |  | 5. DATE OF BIRTH   |  | 6. AGE (IN YEARS)   |  | IF UNDER 1 YR.   |  | IF UNDER 24 HRS.        |  | 2c. DATE PRONOUNCED DEAD  |  |
| Male  |  | Black  |  | 13 Apr 1954  |  | 25 YRS.   |  | MONTHS DAYS  |  | HOURS MIN               |  | 12 21 1979  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  |  |  | 7b. CITIZEN OF WHAT COUNTRY?                             |  |   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |                         |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |  |
| Wash, D.C.  |  |  |  | U.S.A.   |  |   |  |  |  |                         |  | Baltimore City, MD.   |  |
| 10. CITY OR TOWN OF DEATH   |  |  |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |  |                         |  | 12b. KIND OF BUSINESS OR INDUSTRY                                   |  |
| Baltimore   |  |  |  | Sinai Hospital   |  |   |  | Dental Tech  |  |                         |  | DDS/Assit   |  |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  |  |  |  |  | 13d. INSIDE CITY LIMITS?  |  |  |  |                         |  | 13e. STREET ADDRESS   |  |
| 13a. STATE 13b. CITY OR TOWN  |  |  |  |  |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  |  |                         |  | 1004-3rd St, S.W.   |  |
| 13a. D.C.   |  |  |  |  |  | 13b. None   |  |  |  |                         |  | 13c. Washington   |  |
| 14. FATHER'S NAME   |  |  |  |  |  | 15. MOTHER'S MAIDEN NAME  |  |  |  |                         |  |   |  |
| Vivian Pearson  |  |  |  |  |  | Ellen Smith   |  |  |  |                         |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)  |  |  |  |  |  | 16b. SOCIAL SECURITY NO.  |  | 17. INFORMANT ADDRESS  |  |                         |  |   |  |
| YES   |  |  |  |  |  | Air Force   |  | 578-72-5422 Ellen S. Perry (Mother) 1004-3rd St. S.W.  |  |                         |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |  |  |  |  |  |   |  |  |  |                         |  |   |  |
| PART I DEATH WAS CAUSED BY: Cranio-Cerebral Trauma  |  |  |  |  |  |   |  |  |  |                         |  |   |  |
| IMMEDIATE CAUSE (a) 8151  |  |  |  |  |  |   |  |  |  |                         |  |   |  |
| DUE TO, OR AS A CONSEQUENCE OF  |  |  |  |  |  |   |  |  |  |                         |  |   |  |
| Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.   |  |  |  |  |  |   |  |  |  |                         |  |   |  |
| (b)   |  |  |  |  |  |   |  |  |  |                         |  |   |  |
| DUE TO, OR AS A CONSEQUENCE OF  |  |  |  |  |  |   |  |  |  |                         |  |   |  |
| (c)   |  |  |  |  |  |   |  |  |  |                         |  |   |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).   |  |  |  |  |  |   |  |  |  |                         |  |   |  |
| 19a. DATE OF OPERATION  |  |  |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                   |  |  |  |                         |  | 20. AUTOPSY?  |  |
|   |  |  |  |  |  |   |  |  |  |                         |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |  |  |  |  |  | 21b. TIME OF INJURY   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)  |  |                         |  |   |  |
| 5:45 P.M.   |  |  |  |  |  | 12 21 1979  |  | Passenger in auto/fixed object impact  |  |                         |  |   |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>   |  |  |  |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)         |  | 21f. LOCATION  |  |                         |  |   |  |
| street  |  |  |  |  |  | street  |  | 2700 Blk. Purnell Dr., Baltimore City, Md.   |  |                         |  |   |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |  |  |  |  |  |   |  |  |  |                         |  |   |  |
| ACTUAL SIGNATURE  |  |  |  |  |  | TITLE (SPECIFY)   |  |  |  |                         |  | DATE SIGNED   |  |
| Thomas D. Smith   |  |  |  |  |  | Deputy Chief  |  |  |  |                         |  | 12/22/79  |  |
| EXAMINER'S NAME (TYPE OR PRINT)   |  |  |  |  |  | ADDRESS   |  |  |  |                         |  |   |  |
| Thomas D. Smith, M.D.   |  |  |  |  |  | 111 Penn Street   |  |  |  |                         |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   |  |  |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY                                  |  |  |  | 23d. LOCATION           |  |   |  |
| Burial  |  |  |  | 12/28/79   |  | Harmony Cemetery  |  |  |  | Landover, PGC, Maryland |  |   |  |
| 24. FUNERAL DIRECTOR  |  |  |  |  |  | 25a. DATE REC'D. BY REGISTRAR                                       |  |  |  |                         |  | 25b. REGISTRAR'S SIGNATURE  |  |
| Modern Funeral Home   |  |  |  |  |  | DEC 26 1979   |  |  |  |                         |  | L. J. McCreedy  |  |
| 3821-14th St, N.W. Wash, D.C.   |  |  |  |  |  |   |  |  |  |                         |  |   |  |





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed within 72 hours after death. retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, this certificate should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  |  |  |  |  |   |  |   |  |
|--|--|--|--|--|--|--|--|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  | FIRST  |  | MIDDLE   |  | LAST   |  | 2a. DATE OF DEATH MONTH DAY YEAR  |  | 2b. HOUR  |  |
| CHESTER F. PELKOWSKI   |  |  |  |  |  |  |  | 12-17-79  |  | 3 10 M  |  |
| 3 SEX  |  | 4 RACE   |  | 5. DATE OF BIRTH MONTH DAY YEAR  |  | 6 AGE (IN YEARS LAST BIRTHDAY)   |  | IF UNDER 1 YEAR   |  | IF UNDER 24 HRS                                 |  |
| MALE   |  | WHITE  |  | 04 02 24   |  | 55 YRS.  |  | MONTHS DAYS   |  | HOURS MIN                                       |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH  |  |   |  |   |  |
| NEW JERSEY   |  | U.S.A.   |  |  |  | BALTIMORE CITY MD.   |  |   |  |   |  |
| 10 CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NO IN SUCH FACILITY, GIVE STREET ADDRESS) |  |  |  |  |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)  |  | 12b. KIND OF BUSINESS OR INDUSTRY               |  |
| BALTIMORE  |  | ST. AGNES HOSPITAL   |  |  |  |  |  | WAREHOUSE   |  | U.S. STEEL                                      |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  |  |  |  |  |  |  |   |  |   |  |
| 13a. STATE   |  | 13b. COUNTY  |  | 13c. CITY OR TOWN  |  | 13d. INSIDE CITY LIMITS?   |  | 13e. STREET ADDRESS   |  |   |  |
| MARYLAND   |  | BALTIMORE  |  | ARBUTUS  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                  |  | 1823 PALO CIRCLE 21227  |  |   |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST  |  |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST   |  |  |  |   |  |   |  |
| ADAM PELKOWSKI   |  |  |  | ANTOINETTE UNKNOWN   |  |  |  |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)   |  |  |  | 16b. SOCIAL SECURITY NO<br>(IF YES, GIVE WAR OR DATES)   |  | 17 INFORMANT ADDRESS   |  |   |  |   |  |
| YES  |  |  |  | WW II  |  | 147-18-3594 FRANCES PELKOWSKI 1823 PALO CIRCLE, 21227                                |  |   |  |   |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY.<br>IMMEDIATE CAUSE (a) <u>Acute myocardial infarct</u><br>410-<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____  |  |  |  |  |  |  |  |   |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |  |  |  |  |  |  |   |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |  |  |   |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |  |  |   |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>12/16/</u> 19 <u>79</u> , to <u>12/17/</u> 19 <u>79</u> , that (I) (we) lost<br>saw the deceased alive on <u>12/17/</u> 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |  |  |   |  |   |  |
| 22b. SIGNATURE <u>Chyat</u>  |  |  |  | DEGREE   |  |  |  | 22c. DATE SIGNED <u>12/17/79</u>  |  |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><u>KYAW NYUNT</u>   |  |  |  | 22e. ADDRESS<br>900 CATON AVE. BALTIMORE, MD. 21229  |  |  |  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)   |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE   |  |   |  |   |  |
| BURIAL   |  | 12-20-79   |  | CEDAR HILL   |  | BROOKLYN PK. A.A. MD.  |  |   |  |   |  |
| 24 FUNERAL DIRECTOR<br>NAME ADDRESS  |  |  |  | 25a. DATE REC'D. BY REGISTRAR  |  | 25b. REGISTRAR'S SIGNATURE   |  |   |  |   |  |
| HUBBARD FUNERAL HOME, INC. 4107 WILKENS AVE.   |  |  |  | 21229  |  | DEC 19 1979  |  | <u>Robert McCreedy</u>  |  |   |  |

14

BALTIMORE CITY

ST. AGNES HOSPITAL

BALTIMORE

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

*[Faint handwritten text]*

300 BALTIMORE AVE. BALTIMORE, MD. 21201

KYNN WYLLIANT

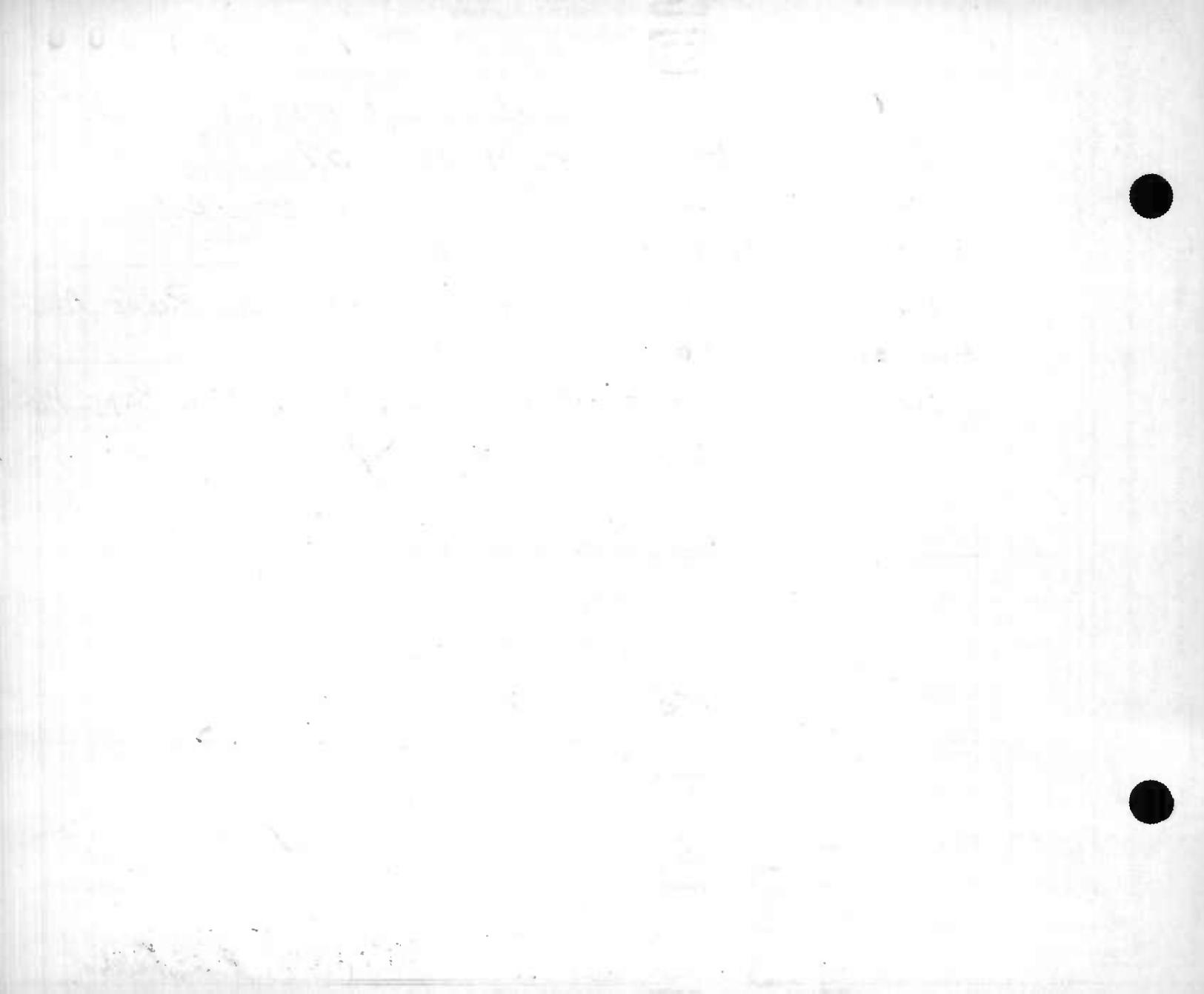
DEC 19 1959

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  |   |  |  |  |   |  |                             |  |
|--|--|--|--|---|--|--|--|---|--|-----------------------------|--|
| 1. FOR STATE REGISTRAR   |  | 79 30500<br>REG. NO.   |  |   |  |  |  |   |  |                             |  |
| 1. DECEASED NAME (TYPE OR PRINT)   |  | FIRST  |  | MIDDLE  |  | LAST   |  | 2a. DATE OF DEATH MONTH DAY YEAR  |  | 2b. HOUR MIN.               |  |
| Doris  |  |  |  |   |  | Perix  |  | 12/21/79  |  | 10:40 A.M.                  |  |
| 3 SEX  |  | 4 RACE   |  | 5. DATE OF BIRTH MONTH DAY YEAR   |  | 6 AGE (IN YEARS LAST BIRTHDAY)   |  | IF UNDER 1 YEAR MONTHS DAYS   |  | IF UNDER 24 HRS. HOURS MIN. |  |
| F  |  | B  |  | 8 19 22   |  | 57 YRS.  |  |   |  |                             |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH  |  |   |  |                             |  |
| Ga.  |  | USA  |  |   |  | Balto. City MD.  |  |   |  |                             |  |
| 10 CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)                                     |  |   |  |  |  |   |  |                             |  |
| Balto.   |  | John C. Dorton Med Ctr.  |  |   |  |  |  |   |  |                             |  |
| 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |  |  |  |   |  |  |  |   |  |                             |  |
| 12b. KIND OF BUSINESS OR INDUSTRY  |  |  |  |   |  |  |  |   |  |                             |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |  |  |   |  |  |  |   |  |                             |  |
| 13a. STATE   |  | 13b. COUNTY  |  | 13c. CITY OR TOWN   |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS   |  |                             |  |
| Md   |  |  |  | Balto.  |  |  |  | 3900 W. Roger Ave.  |  |                             |  |
| 14 FATHER'S NAME FIRST MIDDLE LAST   |  |  |  | 15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST   |  |  |  |   |  |                             |  |
| Alanzo   |  |  |  | Bertha  |  |  |  |   |  |                             |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)  |  |  |  | 16b. SOCIAL SECURITY NO   |  |  |  | 17 INFORMANT ADDRESS  |  |                             |  |
| No   |  |  |  | 214-14-4780   |  |  |  | John Perix 3900 W. Roger Ave.   |  |                             |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |  |  |  |   |  |  |  |   |  |                             |  |
| PART I. DEATH WAS CAUSED BY:   |  |  |  |   |  |  |  |   |  |                             |  |
| IMMEDIATE CAUSE (a) <u>G.I. Myelodysplasia</u>   |  |  |  |   |  |  |  |   |  |                             |  |
| DUE TO, OR AS A CONSEQUENCE OF (b) <u>shunt when</u>   |  |  |  |   |  |  |  |   |  |                             |  |
| DUE TO, OR AS A CONSEQUENCE OF (c) <u>CVA</u>  |  |  |  |   |  |  |  |   |  |                             |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a):   |  |  |  |   |  |  |  |   |  |                             |  |
| <u>Dehydration when</u>  |  |  |  |   |  |  |  |   |  |                             |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>                       |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |                             |  |
|  |  |  |  |   |  |  |  |   |  |                             |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |   |  |                             |  |
|  |  | P.M. 19  |  |   |  |  |  |   |  |                             |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |  |  |   |  |                             |  |
|  |  |  |  |   |  |  |  |   |  |                             |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>10-19</u> 19 <u>79</u> , to <u>12-21</u> 19 <u>79</u> , that (I) (we) last saw the deceased alive on <u>12-19</u> 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death. |  |  |  |   |  |  |  |   |  |                             |  |
| 22b. SIGNATURE   |  | DEGREE   |  |   |  |  |  | 22c. DATE SIGNED  |  |                             |  |
| <u>Martha Perix M.D.</u>   |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  |   |  |  |  | <u>12/21/79</u>   |  |                             |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  | 22e. ADDRESS   |  |   |  |  |  |   |  |                             |  |
| MARIE POSWEN   |  | 6806 BONNIE RIDGE DR #11   |  |   |  |  |  |   |  |                             |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE  |  |   |  |                             |  |
| Burial   |  | 12/27/79   |  | King Mem. Pk.   |  | Baltimore Co., Md.   |  |   |  |                             |  |
| 24 FUNERAL DIRECTOR NAME   |  | 24b. ADDRESS   |  |   |  |  |  | 25a. DATE REC'D. BY REGISTRAR   |  | 25b. REGISTRAR'S SIGNATURE  |  |
| Wm C March F/H   |  | 1101 E. North Ave.   |  |   |  |  |  | DEC 26 1979   |  | <u>Edith A. Brady</u>       |  |



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 3 FOR YOUR FILES.

TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PENNSYLVANIA AVENUE, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. No. 3050

|   |  |   |  |   |  |                                   |  |  |  |                       |  |                          |  |           |  |
|---|--|---|--|---|--|-----------------------------------|--|--|--|-----------------------|--|--------------------------|--|-----------|--|
| 1. FOR STATE REGISTRAR  |  | MEDICAL EXAMINER'S CERTIFICATE OF DEATH                     |  |   |  |                                   |  |  |  |                       |  | 7 9                      |  | 3 0 5 0 1 |  |
| DECEASED NAME (TYPE OR PRINT)   |  | FIRST   |  | MIDDLE  |  | LAST                              |  | 2a. DATE KNOWN OF DEATH                |  | X MONTH DAY YEAR      |  | 2b. HOUR                 |  |           |  |
| Joseph  |  | N.  |  | Penn  |  |                                   |  | 12 22 19 79                            |  |                       |  |                          |  |           |  |
| 3. SEX  |  | 4. RACE   |  | 5. DATE OF BIRTH  |  | 6. AGE (IN YEARS)                 |  | IF UNDER 1 YR.                         |  | IF UNDER 24 HRS.      |  | 2c. DATE PRONOUNCED DEAD |  |           |  |
| male  |  | black   |  | 12 5 25   |  | 54 YRS.                           |  | MONTHS DAYS HOURS MIN.                 |  |                       |  | 12 22 19 79              |  |           |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  | 7b. CITIZEN OF WHAT COUNTRY?                                |  | 8. MARRIED  |  | NEVER MARRIED                     |  | 9. BALTIMORE CITY OR COUNTY OF DEATH   |  |                       |  |                          |  |           |  |
| Va.   |  | USA   |  | WIDOWED   |  | DIVORCED                          |  | Baltimore City                         |  |                       |  |                          |  |           |  |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION    |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                 |  | 12b. KIND OF BUSINESS OR INDUSTRY |  |  |  |                       |  |                          |  |           |  |
| Baltimore   |  | 5208 Linden Hgts. Avenue                                    |  |   |  |                                   |  |  |  |                       |  |                          |  |           |  |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  | 13a. STATE  |  | 13b. COUNTY   |  | 13c. CITY OR TOWN                 |  | 13d. INSIDE CITY LIMITS?               |  | 13e. STREET ADDRESS   |  |                          |  |           |  |
|   |  | Md.   |  |   |  | Balto.                            |  | YES X NO                               |  | 5208 Linden Hgts Ave. |  |                          |  |           |  |
| 14. FATHER'S NAME   |  | 15. MOTHER'S MAIDEN NAME                                    |  |   |  |                                   |  |  |  |                       |  |                          |  |           |  |
| Unkn  |  | Unkn  |  |   |  |                                   |  |  |  |                       |  |                          |  |           |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)  |  | 16b. SOCIAL SECURITY NO.                                    |  | 17. INFORMANT   |  | ADDRESS                           |  |  |  |                       |  |                          |  |           |  |
| Yes   |  | 233-32-2760   |  | Ann Savoy   |  | 5208 Linden Ave.                  |  |  |  |                       |  |                          |  |           |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                |  |   |  |                                   |  |  |  |                       |  |                          |  |           |  |
| PART 1 DEATH WAS CAUSED BY:   |  |   |  |   |  |                                   |  |  |  |                       |  |                          |  |           |  |
| IMMEDIATE CAUSE (a)   |  |   |  |   |  |                                   |  |  |  |                       |  |                          |  |           |  |
| 4292  |  |   |  |   |  |                                   |  |  |  |                       |  |                          |  |           |  |
| Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.                                       |  |   |  |   |  |                                   |  |  |  |                       |  |                          |  |           |  |
| DUE TO, OR AS A CONSEQUENCE OF  |  |   |  |   |  |                                   |  |  |  |                       |  |                          |  |           |  |
| (b)   |  |   |  |   |  |                                   |  |  |  |                       |  |                          |  |           |  |
| DUE TO, OR AS A CONSEQUENCE OF  |  |   |  |   |  |                                   |  |  |  |                       |  |                          |  |           |  |
| (c)   |  |   |  |   |  |                                   |  |  |  |                       |  |                          |  |           |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). |  |   |  |   |  |                                   |  |  |  |                       |  |                          |  |           |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?           |  | 20. AUTOPSY?  |  |                                   |  |  |  |                       |  |                          |  |           |  |
|   |  |   |  | YES NO XX   |  |                                   |  |  |  |                       |  |                          |  |           |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH   |  | 21b. TIME OF INJURY   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) |  |                                   |  |  |  |                       |  |                          |  |           |  |
|   |  | P.M. 19   |  |   |  |                                   |  |  |  |                       |  |                          |  |           |  |
| 21d. INJURY OCCURRED WHILE AT WORK  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) |  | 21f. LOCATION   |  |                                   |  |  |  |                       |  |                          |  |           |  |
| NOT WHILE AT WORK   |  |   |  | STREET CITY OR TOWN COUNTY STATE  |  |                                   |  |  |  |                       |  |                          |  |           |  |
| 22a. I certify that I took charge of the remains described above, held on   |  | Autopsy   |  | Inspection  |  | Inquiry XX                        |  | and in my opinion death resulted from: |  |                       |  |                          |  |           |  |
| Natural causes XX   |  | Accident  |  | Suicide   |  | Homicide                          |  | Undetermined manner                    |  |                       |  |                          |  |           |  |
| ACTUAL SIGNATURE  |  | TITLE (SPECIFY)   |  | DATE  |  |                                   |  |  |  |                       |  |                          |  |           |  |
| Margarita A. Korell   |  | Assistant   |  | 12/26/79  |  |                                   |  |  |  |                       |  |                          |  |           |  |
| EXAMINER'S NAME (TYPE OR PRINT)   |  | ADDRESS   |  |   |  |                                   |  |  |  |                       |  |                          |  |           |  |
| Margarita A. Korell, M.D.   |  | 111 Penn Street, Balto., MD                                 |  |   |  |                                   |  |  |  |                       |  |                          |  |           |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   |  | 23b. DATE   |  | 23c. NAME OF CEMETERY OR CREMATORY  |  | 23d. LOCATION                     |  |  |  |                       |  |                          |  |           |  |
| Burial  |  | 12/27 /79   |  | Cheltenham Vet.   |  | Cheltenham Md.                    |  |  |  |                       |  |                          |  |           |  |
| 24. FUNERAL DIRECTOR NAME   |  | ADDRESS   |  | 25a. DATE REC'D. BY REGISTRAR   |  | 25b. SIGNATURE                    |  |  |  |                       |  |                          |  |           |  |
| Wm C March F/H  |  | 1101 E. North Ave.  |  | DEC 28 1979   |  | [Signature]                       |  |  |  |                       |  |                          |  |           |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

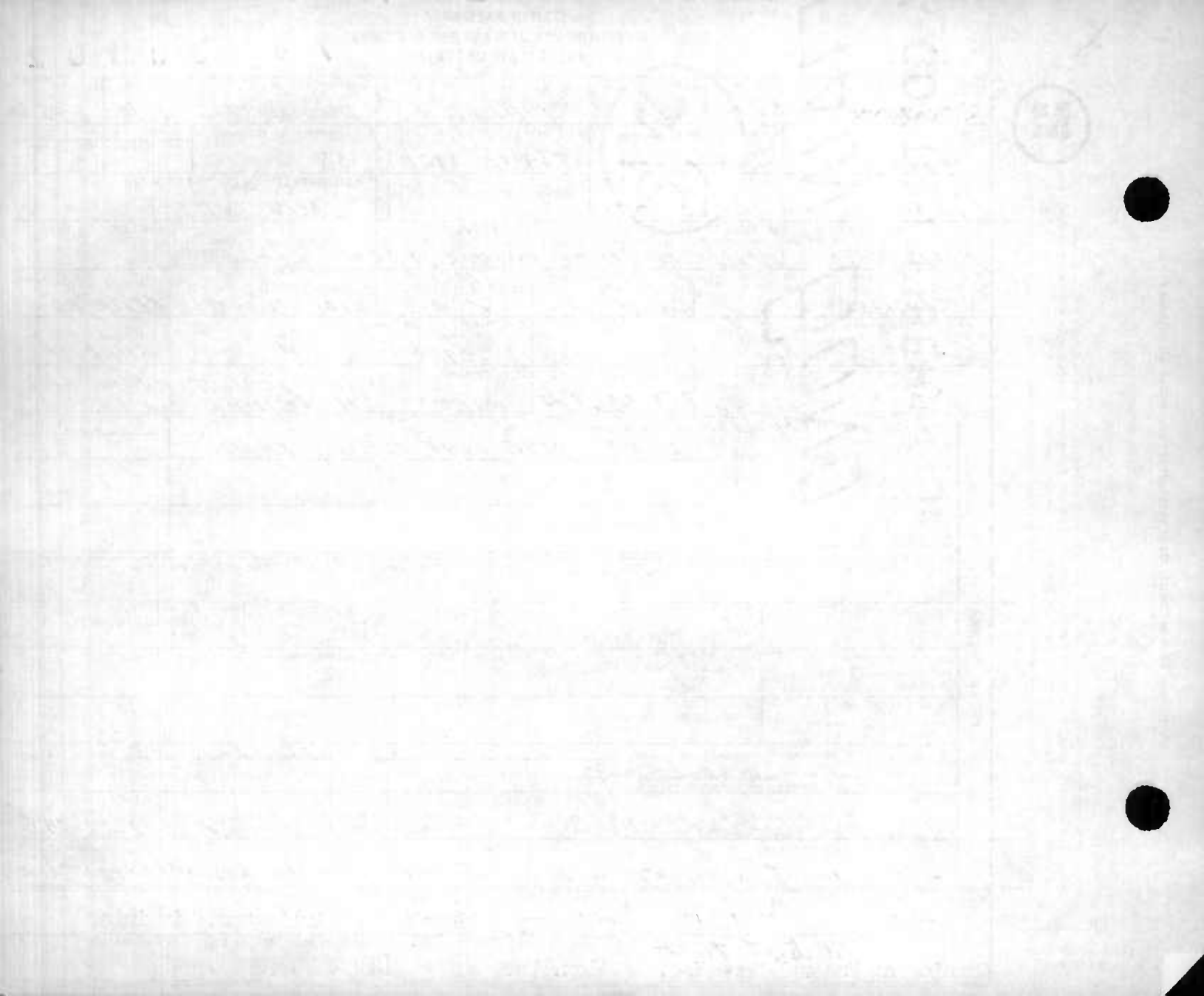
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 50M 1/76  
(VR A 15 (4))1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH7 9 3 0 5 0 2  
REG. NO.

|   |  |  |  |   |  |  |   |  |   |   |  |
|---|--|--|--|---|--|--|---|--|---|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><del>DECEASED</del> ROSS C PENNINGTON  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>DECEMBER 22 1979                |   |  | 2b. HOUR<br>1:45 AM  |   |  |   |   |  |
| 3. SEX<br>MALE  |  | 4. RACE<br>CAUCASIAN   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>JAN 15 1921   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>58 YRS  |   | 7. IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.   |   |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>S. CAROLINA  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>UNITED STATES  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTO CITY MD.   |   |  |   |   |  |
| 10. CITY OR TOWN OF DEATH<br>BALTO CITY   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>BALTIMORE CANCER RESEARCH PROGRAM RETIRED |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>RETIRED  |   | 12b. KIND OF BUSINESS OR INDUSTRY  |   |   |  |
| 13a. STATE<br>N. CAROLINA   |  |  | 13b. COUNTY<br>CHARLOTTE   |   | 13c. CITY OR TOWN<br>CHARLOTTE                           |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br>3101 MOUNTAIN BROOK RD |   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>ROSS C. PENNINGTON  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>ETHEL M. MURRAY       |   |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>YES WORLD WAR II                       |   |  |   | 16b. SOCIAL SECURITY NO.<br>250 01 6894 |  |
| 17. INFORMANT<br>WIFE   |  |  | 18. ADDRESS<br>3101 MOUNTAIN BROOK RD<br>N. CAROLINA 28240             |   |  | 19. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |   |  |   |   |  |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) ACUTE MYELOCYTIC LEUKEMIA<br>2050 DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____  |  |  |  |   |  |  |   |  |   |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____   |  |  |  |   |  |  |   |  |   |   |  |
| 19a. DATE OF OPERATION  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |   |  |   |   |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |   |  |   |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from NOV. 8, 1977, to DEC. 22, 1979, that (I) (we) last saw the deceased alive on DEC. 22, 1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |   |  |  |   |  |   |   |  |
| 22b. SIGNATURE<br>Lydia M. Juncamoy, M.D.   |  |  | DEGREE<br>M.D.   |   |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |   | 22c. DATE SIGNED<br>12-22-79   |   |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>LYDIA M. JUNCAMOY, M.D.  |  |  | 22e. ADDRESS<br>BALTIMORE CANCER RESEARCH CENTER-NC                    |   |  |  |   |  |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial  |  |  | 23b. DATE<br>12/27/79  |   | 23c. NAME OF CEMETERY OR CREMATORY<br>Arlington National |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Arlington, Virginia                               |  |   |   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Walter T. Holt  |  |  | ADDRESS<br>Cunningham Funeral Home, Inc.                               |   | 25a. DATE REC'D. BY REGISTRAR<br>DEC 31 1979             |  | 25b. REGISTRAR'S SIGNATURE<br>F. J. McCreedy  |  |   |   |  |







TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |   |  |  |  |   |  |   |  |
|--|--|--|---|--|--|--|---|--|---|--|
| 1. FOR STATE REGISTRAR   |  |  |   |  |  |  |   |  |   |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br><b>CHARLES L. PERRY, Sr.</b>   |  |  |   |  | 2a. DATE OF DEATH<br><b>DECEMBER 24, 1979</b>  |  | 2b. HOUR<br><b>11: A M</b>  |  |   |  |
| 3. SEX<br><b>M</b>   |  | 4. RACE<br><b>B</b>  |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>12 23 97</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>82</b> YRS                                     |   | 7. IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.   |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Ga.</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. <b>BALTIMORE CITY OR COUNTY OF DEATH</b><br><b>BALTIMORE CITY</b> MD.             |   |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Balto.</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>THE JOHNS HOPKINS HOSPITAL</b> |   |  |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)                     |   | 12b. KIND OF BUSINESS OR INDUSTRY  |   |  |
| 13a. STATE<br><b>Md.</b>   |  |  |   |  | 13b. COUNTY<br><b>Balto.</b>   |  | 13c. CITY OR TOWN<br><b>Balto.</b>                                      |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Pledge Perry</b>  |  |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Cornelius Cooper</b>   |  |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>  |  |  | 16b. SOCIAL SECURITY NO<br><b>213-01-6334</b>   |  | 17. INFORMANT<br>ADDRESS<br><b>Mary Perry 1826 E. 32nd St.</b>   |  |   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1 DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <b>Respiratory Arrest</b><br><b>7373</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost<br>(c) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |  |  |   |  |  |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>40 min</b>  |   |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |  |   |  |  |  |   |  |   |  |
| 19a. DATE OF OPERATION<br><b>12/3/79</b>   |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>Lumbar Scoliosis + Spondylolysis</b> |  |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>                           |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)       |   |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                      |  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |   |  |   |  |
| 22a. I certify that (1) (this hospital) attended the deceased from <b>12/24</b> , 19 <b>79</b> , to <b>12/24</b> , 19 <b>79</b> , that (1) (6) lost<br>saw the deceased alive on <b>12/24</b> , 19 <b>79</b> , and that in (1) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (1) (we) (did) (did not) view the body after death.          |  |  |   |  |  |  |   |  |   |  |
| 22b. SIGNATURE<br><b>Gary Mofram</b>   |  |  |   |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  |   | 22c. DATE SIGNED<br><b>12/24/79</b>  |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>GARY MOFRAM</b>  |  |  |   |  | 22e. ADDRESS<br><b>Johns Hopkins Hospital, Balt. Md 21205</b>  |  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |  |  | 23b. DATE<br><b>12/29/79</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>King Mem. Pk.</b>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Co., Md.</b> |  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Wm C March F/H</b>  |  |  | ADDRESS<br><b>1101 E. North Ave.</b>  |  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>DEC 26 1979</b>                                  |   | 25b. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>   |   |  |

U. S. DEPARTMENT OF THE INTERIOR

OFFICE OF THE SECRETARY  
WASHINGTON, D. C.  
JANUARY 10, 1900

THE LANDS COMMISSION  
WASHINGTON, D. C.  
SIR:  
I have the honor to acknowledge the receipt of your letter of the 7th inst. in relation to the matter of the proposed sale of the lands of the United States in the State of California.

Very respectfully,  
Yours truly,  
J. M. Smith  
Secretary

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

79 30504

1. FOR  
STATE  
REGISTRAR

JAY

REG. NO.

1. DECEASED NAME  
(TYPE OR PRINT)

JAY DANIEL PERRY

2a. DATE OF DEATH MONTH DAY YEAR 12 23 79 2b. HOUR 4:55 P.M.

3 SEX

MALE

4. RACE

WHITE

5. DATE OF BIRTH

MONTH DAY YEAR 12 22 79

6. AGE (IN YEARS LAST BIRTHDAY)

0

IF UNDER 1 YEAR

MONTHS DAYS HOURS MIN.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)

MD

7b. CITIZEN OF WHAT COUNTRY?

USA

8 MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

9 BALTIMORE CITY OR COUNTY OF DEATH

FREDERICK City MD

10 CITY OR TOWN OF DEATH

BALTO

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)

UNIVERSITY

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)

12b. KIND OF BUSINESS OR INDUSTRY

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE

Maryland

13b. COUNTY

Frederick

13c. CITY OR TOWN

Frederick

13d. INSIDE CITY LIMITS?

YES ☒ NO ☐

13e. STREET ADDRESS

309 Dulaney Ave. Frederick, Maryland

14. FATHER'S NAME

GEORGE H

PERRY

15. MOTHER'S MAIDEN NAME

CAROL

Gough

PERRY

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)

NO

16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)

None

17. INFORMANT

Mr. George H. Perry, 309 Dulaney Ave., Frederick, Maryland 21701

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) CARDIOPULMONARY ARREST

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

3

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

(b) HYPOTENSION

DUE TO, OR AS A CONSEQUENCE OF

(c) CAUSE TO BE DETERMINED AT AUTOPSY

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

HYPOGLYCEMIA, ABDOMINAL MASS, HEART MURMUR, HIP DISC

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY?

YES ☒ NO ☐

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?

YES ☐ NO ☐21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19

21c. HOW INJURY OCCURRED

(ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21d. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (this hospital) attended the deceased from 8 AM 12-23, 1979, to 4:55 PM 12-23, 1979, that (I) (we) last saw the deceased alive on 4:55 PM 12-23, 1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE

Michael E. Msall

DEGREE

ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☐ PHYSICIAN ☒

22c. DATE SIGNED 12-23-79

22d. PHYSICIAN'S NAME (TYPE OR PRINT)

MICHAEL MSALL

22e. ADDRESS

UNIV MD HOSP/DEPT PEDIATRS

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)

BURIAL

23b. DATE

Jan 2, 1980

23c. NAME OF CEMETERY OR CREMATORY

St. Paul's Cemetery

23d. LOCATION CITY OR TOWN COUNTY STATE

Pt. of Rocks Frederick Md.

24. FUNERAL DIRECTOR NAME

SMITH

25a. DATE REC'D. BY REGISTRAR

JAN 3 1980

25b. REGISTRAR'S SIGNATURE

FADLEY

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 25M

(VR A 15 (4) 1/74



X

X

President Frederick

XXXXXXXXXX

Mr. George H. Perry, 309 Duane St., New York, N.Y. 10011

None

BOX COTTON LEEB



Jan. 2, 1960 St. Louis, Missouri

Jan. 2, 1960

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

79 30505

1- FOR  
STATE  
REGISTRAR

|   |  |  |  |   |  |   |  |
|---|--|--|--|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Stella</b>   |  | FIRST <b>Stella</b> MIDDLE <b>M.</b> LAST <b>Perzynski</b>   |  | 2a. DATE OF DEATH MONTH <b>12</b> DAY <b>27</b> YEAR <b>79</b>  |  | 2b. HOUR <b>7:30 AM</b>   |  |
| 3. SEX <b>Female</b>  |  | 4. RACE <b>White</b>   |  | 5. DATE OF BIRTH MONTH <b>04</b> DAY <b>17</b> YEAR <b>04</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY) <b>75</b> YRS MONTHS <b>0</b> DAYS <b>0</b> IF UNDER 1 YEAR IF UNDER 24 HRS. HOURS <b>0</b> MIN. <b>0</b> |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Missouri</b>   |  | 7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>                          |  | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD   |  |
| 10. CITY OR TOWN OF DEATH <b>Baltimore</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Baltimore City Hospitals</b>     |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |
| 13a. STATE <b>Maryland</b>  |  | 13b. COUNTY <b>Baltimore</b>   |  | 13c. CITY OR TOWN <b>Dundalk</b>  |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |
| 14. FATHER'S NAME FIRST <b>Zacharuesz</b> MIDDLE <b>Machlinski</b> LAST <b>Machlinski</b>   |  | 15. MOTHER'S MAIDEN NAME FIRST <b>Magdelina</b> MIDDLE <b>Imbierowicz</b> LAST <b>Imbierowicz</b>  |  | 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b> 16b. SOCIAL SECURITY NO. <b>218-48-4886</b> 17. INFORMANT <b>Joseph C. Perzynski - Balto. MD 21224</b> |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <b>cardiopulmonary arrest</b> 410-<br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>myocardial infarction</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (c) <b>Coronary atherosclerotic disease</b> |  |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |  |  |   |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>                   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>Dec 18</b> 19 <b>79</b> to <b>Dec 27</b> 19 <b>79</b> , that (I) (we) lost <b>saw the deceased alive on Dec 26</b> 19 <b>79</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.  |  |  |  |   |  |   |  |
| 22b. SIGNATURE <b>Sandra W. Warden</b> DEGREE <b>MD</b>   |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  |   |  | 22c. DATE SIGNED <b>12/27/79</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>SANDRA WARDEN</b>  |  | 22e. ADDRESS <b>BCTB</b>   |  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>   |  | 23b. DATE <b>12/29/79</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY <b>St. Stanislaus</b>  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore Maryland</b>   |  |
| 24. FUNERAL DIRECTOR <b>Duda-Ruck, Inc.</b> ADDRESS <b>7922 Wise Avenue, Dundalk, MD 21222</b>  |  |  |  | 25a. DATE REC'D. BY REGISTRAR <b>DEC 28 1979</b>  |  | 25b. REGISTRAR'S SIGNATURE <b>P. J. Kelly</b>   |  |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal with the State Dept. of Health and Mental Hygiene.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 7 days after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  |   |  |  |  |  |  |   |  |
|---|--|--|--|---|--|--|--|--|--|---|--|
| 1. FOR<br>STATE<br>REGISTRAR  |  | 7 3 0 5 0 6<br>REG. NO.  |  |   |  |  |  |  |  |   |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |  | FIRST  |  | MIDDLE  |  | LAST   |  | 2a. DATE OF DEATH MONTH DAY YEAR   |  | 2b. HOUR  |  |
| Dr. Michael James Pescor  |  |  |  |   |  |  |  | 12-5-79  |  | 3 P M   |  |
| 3. SEX  |  | 4. RACE  |  | 5. DATE OF BIRTH  |  | 6. AGE (IN YEARS LAST BIRTHDAY)  |  | IF UNDER 1 YEAR  |  | IF UNDER 24 HRS   |  |
| Male  |  | White  |  | June 1, 1904  |  | 75   |  | MONTHS DAYS  |  | HOURS MIN   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH   |  |  |  |   |  |
| Minnesota   |  | U S A  |  |   |  | Baltimore City MD  |  |  |  |   |  |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |   |  |  |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)   |  | 12b. KIND OF BUSINESS OR INDUSTRY                                 |  |
| Baltimore   |  | Jenkins Memorial Home<br>1000 S. Caton Ave. Balt; Md. 21229  |  |   |  |  |  | Physician  |  | U S Public Health   |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |  |  |   |  |  |  |  |  |   |  |
| 13a. STATE  |  | 13b. COUNTY  |  | 13c. CITY OR TOWN   |  | 13d. INSIDE CITY LIMITS?   |  | 13e. STREET ADDRESS  |  |   |  |
| Maryland  |  | Baltimore  |  | Catonsville   |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | 1231 Blackfrairs Road  |  |   |  |
| 14. FATHER'S NAME   |  |  |  |   |  | 15. MOTHER'S MAIDEN NAME   |  |  |  |   |  |
| FIRST MIDDLE LAST<br>Michael Pescor   |  |  |  |   |  | FIRST MIDDLE LAST<br>Johanna Luschin   |  |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)  |  |  |  | 16b. SOCIAL SECURITY NO.  |  | 17. INFORMANT ADDRESS  |  |  |  |   |  |
| no  |  |  |  | 245-38-9890   |  | Anne Leonard, 6308 Swords Way Bethesda, Md                                     |  |  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Bilateral Greenman's<br>4029<br>Conditions, if any, which<br>gave rise to immediate<br>cause (a), stating the<br>underlying cause last<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) Hypertension, A.S.E.V.D.<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) Parkinson Disease |  |  |  |   |  |  |  |  |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH                   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |  |  |   |  |  |  |  |  |   |  |
| 19a. DATE OF OPERATION  |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  |  | 20a. AUTOPSY?  |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH? |  |
|   |  |  |  |   |  |  |  | YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | YES <input type="checkbox"/> NO <input type="checkbox"/>          |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |  |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/><br>AT WORK  |  |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |  |  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 3-7-77, 19, to 12-5-79, 19, that (I) (we) lost<br>saw the deceased alive on 12-5-79, 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.   |  |  |  |   |  |  |  |  |  |   |  |
| 22b. SIGNATURE  |  |  |  |   |  | DEGREE   |  | 22c. DATE SIGNED   |  |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  |  |  |   |  | 22e. ADDRESS   |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  |   |  |
| GEORGE BURGOL   |  |  |  |   |  | 3350 Wilkens Dr - Baltimore  |  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)  |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE                                     |  |  |  |   |  |
| Burial  |  | 12/10/79   |  | Loudon Park Cem.  |  | Baltimore, Maryland  |  |  |  |   |  |
| 24. FUNERAL DIRECTOR 1630 Edmondson Ave., Catonsville, Md<br>NAME ADDRESS   |  |  |  |   |  | 25a. DATE REC'D. BY REGISTRAR  |  | 25b. REGISTRAR'S SIGNATURE   |  |   |  |
| Witzke Funeral Home of Catonsville, P.A. 21228  |  |  |  |   |  | DEC 7 1979   |  | R. J. H. H. H.   |  |   |  |



Dr. Michael J. Mason

1000 S. Carson Ave. Suite 2122  
Tombstone Memorial Home

RECEIVED BY THE OFFICE OF THE ATTORNEY GENERAL  
DEC 7 1979



STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

7 9 30507

1- FOR  
STATE  
REGISTRAR

|  |  |   |  |   |   |  |   |   |  |  |
|--|--|---|--|---|---|--|---|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FREDERICK JOSEPH PETRELLA SR.   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>12/11/79                        |   |   | 2b. HOUR<br>6/30/P   |   |   |  |  |
| 3. SEX<br>M  |  | 4. RACE<br>W  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>7/28/03   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>76 yrs  |   | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>BALTO. Md.  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>CITY MD.   |   |   |  |  |
| 10. CITY OR TOWN OF DEATH<br>BALTO.  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>MERCY HOS. |  |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>CONSTRUCTION   |   | 12b. KIND OF BUSINESS OR INDUSTRY<br>BLDG.  |  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>Md.  |  |   | 13b. COUNTY<br>BALTO.  |   | 13c. CITY OR TOWN<br>BALTO.   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   | 13e. STREET ADDRESS<br>1017 STILES ST. |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>JOSEPH A. PETRELLA   |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>FRANCES CECI   |   |  |   |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>NO   |  |   | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>220-12-5840 |   | 17. INFORMANT<br>ADDRESS<br>MARGARET PETRELLA 1017 STILES ST.                 |  |   |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>TERMINAL CONGESTIVE HEART FAILURE</u><br>4409 DUE TO, OR AS A CONSEQUENCE OF<br>ASVD<br>(b)<br>DUE TO, OR AS A CONSEQUENCE OF<br>ATRIAL FIBRILLATION<br>(c)  |  |   |  |   |   |  |   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH   |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |   |  |   |   |  |   |   |  |  |
| 19a. DATE OF OPERATION   |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |   |   |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |   |   |  |  |
| 22a. I certify that (I) (his hospital) attended the deceased from <u>12-11</u> , 19 <u>79</u> , to <u>12-11</u> , 19 <u>79</u> , that (I) (we) lost<br>saw the deceased alive on <u>12-11</u> , 19 <u>79</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death. |  |   |  |   |   |  |   |   |  |  |
| 22b. SIGNATURE<br>J. Gaber MD  |  |   |  |   |   | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |   | 22c. DATE SIGNED<br>12/11/79  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>J. Gaber MD   |  |   |  |   |   | 22e. ADDRESS   |   |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY) BURIAL  |  |   | 23b. DATE<br>12/15/79  |   | 23c. NAME OF CEMETERY OR CREMATORY<br>HOLY REDEEMER 4400 BELAIR RD. BALTO. Md |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE  |   |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>BELLA NOCE & SONS 322 D. HIGH ST.  |  |   |  |   |   | 25a. DATE REC'D. BY REGISTRAR<br>DEC 14 1979   |   | 25b. REGISTRAR'S SIGNATURE<br>[Signature]   |  |  |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR  
1 - STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

7 9 3 0 5 0 8

|  |  |  |   |  |  |
|--|--|--|---|--|--|
| 1 DECEASED NAME<br>(TYPE OR PRINT) 2 (KATHERINE ADELAIDE PETROCCARO-FRIES)<br>KATHERINE PETROCCARO   |  | 2a DATE OF DEATH MONTH DAY YEAR<br>12-20-79  |   | 2b HOUR<br>7:50 PM   |  |
| 3 SEX<br>FEMALE  | 4 RACE<br>WHITE  | 5 DATE OF BIRTH<br>MONTH DAY YEAR<br>JANUARY 4, 1915   |   | 6 AGE (IN YEARS LAST BIRTHDAY)<br>64 YRS.  |  |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>BALTIMORE, MD.   | 7b CITIZEN OF WHAT COUNTRY?<br>U.S.A.  | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9 BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY, MD.                                     |  |
| 10 CITY OR TOWN OF DEATH<br>BALTIMORE, MD.   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>CHURCH HOSPITAL, INC. |  | 12a USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>REPRESENTATIVE |  | 12b KIND OF BUSINESS OR INDUSTRY<br>BRENNAN REALTOR, CO. |
| 13a STATE<br>MD.   |  | 13b COUNTY<br>-----  | 13c CITY OR TOWN<br>BALTIMORE   | 13d INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e STREET ADDRESS<br>433 JOPLIN ST. # 21224.            |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br>LOUIS A. ARNETT   |  | 15 MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>MARY V. HOLZNER  |   |  |  |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>NO  |  | 16b SOCIAL SECURITY NO<br>(IF YES, GIVE WAR OR DATES)<br>-----<br>217-14-5446  |   | 17 INFORMANT ADDRESS<br>433 JOPLIN ST.<br>MICHAEL J. PETROCCARO ; BALTO., 21224, MD.           |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) CARDIAC ARREST<br>3481<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) CEREBRAL ANOXIA<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(c) RESPIRATORY FAILURE |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH             |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)<br>CHRONIC OBSTRUCTIVE LUNG DISEASE   |  |  |   |  |  |
| 19a DATE OF OPERATION  |  | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                       |  |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)                  |  |
| 21d INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |
| 22a I certify that (1) this hospital attended the deceased from 12-07-1979, to 12-20-1979, that (1) we lost saw the deceased alive on 12-20-1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death.                                 |  |  |   |  |  |
| 22b SIGNATURE<br>Joseph Mac Mahon  |  | DEGREE   |   | 22c DATE SIGNED  |  |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT)<br>DR. JOSEPH MACMAHON  |  | 22e ADDRESS<br>CHURCH HOSPITAL CORPORATION<br>100 N. BROADWAY BALTIMORE, MARYLAND 31   |   |  |  |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY)<br>BURIAL   |  | 23b DATE<br>12-24-79   |   | 23c NAME OF CEMETERY OR CREMATORY<br>GLEN HAVEN MEM. PARK                                      |  |
| 23d LOCATION<br>CITY OR TOWN COUNTY STATE<br>RITCHIE HIGHWAY, A.A.CO., MD.   |  | 23e DATE REC'D. BY REGISTRAR<br>DEC 24 1979  |   |  |  |
| 24 FUNERAL DIRECTOR<br>NAME<br>Charles J. Jailer + Son, Inc.   |  | 6224 EASTERN AVE.<br>BALTO., 21224, MD.  |   | 25b REGISTRAR'S SIGNATURE<br>[Signature]   |  |

(UNITED STATES DEPARTMENT OF JUSTICE)

IN

REPLY TO LETTER

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  |  |   |  |  |   |   |  |
|---|--|---|--|--|---|--|--|---|---|--|
| 1. FOR STATE REGISTRAR  |  | 7 9 3 0 5 0 9   |  | REG. NO.   |   |  |  |   |   |  |
| 1 DECEASED NAME (TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>CHARLES R. PFANNENSTIEL   |  |   | 2a DATE OF DEATH MONTH DAY YEAR<br>12/14/79                        |  |   | 2b HOUR<br>1:50 PM   |  |   |   |  |
| 3 SEX<br>MALE   |  | 4 RACE<br>WHITE   |  | 5 DATE OF BIRTH MONTH DAY YEAR<br>1 20 36  |   | 6 AGE (IN YEARS LAST BIRTHDAY)<br>43 YRS.  |  | 7 UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.  |   |  |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>MARYLAND  |  | 7b CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9 BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD.  |  |   |   |  |
| 10 CITY OR TOWN OF DEATH<br>BALTIMORE   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>ST AGNES HOSPITAL |  |  |   | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>POLICE OFFICER   |  | 12b KIND OF BUSINESS OR INDUSTRY<br>BALTO. CITY   |   |  |
| 13a STATE<br>MARYLAND   |  |   | 13b COUNTY<br>HOWARD   |  | 13c CITY OR TOWN<br>ELKRIDGE                          |  | 13d INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 13e STREET ADDRESS<br>7234 MONTGOMERY RD. APT. 36 |  |
| 14 FATHER'S NAME FIRST MIDDLE LAST<br>NORMAN G. PFANNENSTIEL  |  |   | 15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>ANNA M. KIRK          |  |   |  |  |   |   |  |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>YES   |  |   | 16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)<br>1957-1960   |  | 17 INFORMANT<br>NELLIE PFANNENSTIEL                   |  | ADDRESS<br>7234 MONTGOMERY RD. APT 36  |   |   |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Cerebral Vascular Accident</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |   |  |  |   |  |  |   |   |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |   |  |  |   |  |  |   |   |  |
| 19a DATE OF OPERATION   |  |   | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED                    |  |   | 20a AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |  |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   | 21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  |   | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |   |  |
| 21d INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |   | 21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  |   | 21f LOCATION STREET CITY OR TOWN COUNTY STATE  |  |   |   |  |
| 22a I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.        |  |   |  |  |   |  |  |   |   |  |
| 22b SIGNATURE<br><u>Stephen J. Plantholt</u>  |  |   |  |  |   | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c DATE SIGNED<br>12/15/79   |   |  |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT)<br>Dr. Stephen Plantholt   |  |   |  |  |   | 22e ADDRESS<br>900 S CATON AVE BALTO MD 21229  |  |   |   |  |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY)<br>BURIAL  |  |   | 23b DATE<br>12/18/79   |  | 23c NAME OF CEMETERY OR CREMATORY<br>WESTERN CEMETERY |  | 23d LOCATION CITY OR TOWN COUNTY STATE<br>BALTIMORE MD.  |   |   |  |
| 24 FUNERAL DIRECTOR NAME<br>HUBBARD FUNERAL HOME 4107 WILKENS AVE. 21229  |  |   |  |  |   | 25a DATE REC'D. BY REGISTRAR<br>DEC 17 1979  |  | 25b REGISTRAR'S SIGNATURE<br><u>Robert McCreedy</u>   |   |  |

1 4 0 0 0

WILMINGTON CITY

ST. JAMES HOSPITAL

ST. JAMES HOSPITAL

1927

ST. JAMES HOSPITAL

ST. JAMES HOSPITAL

ST. JAMES HOSPITAL

ST. JAMES HOSPITAL



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, THE MEDICAL EXAMINER SHOULD EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL HOME. GIVE PAGE 4 TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR THE MEDICAL EXAMINER. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITH THE DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP  
DHMH - 17  
(VR A15 ME(5))  
30M 7/73

| FOR<br>1- STATE<br>REGISTRAR  |  |                  |  |   |  |   |  |   |  | DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH                    |  |   |   |  |  |  |  |  |  | REG. NO. 30510        |  |                 |  |
|---|--|------------------|--|---|--|---|--|---|--|---|--|---|---|--|--|--|--|--|--|-----------------------|--|-----------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) FIRST MIDDLE LAST<br>Mary E. Pfeifer  |  |                  |  |   |  |   |  |   |  | 20. DATE KNOWN OF DEATH<br>ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR<br>12 8 19 79 |  |   |   |  |  |  |  |  |  | 26. HOUR<br>M<br>4:58 |  |                 |  |
| 3. SEX<br>Female  |  | 4. RACE<br>White |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>7 4 26  |  | 6. AGE (IN YEARS)<br>LAST BIRTHDAY<br>53 YRS.             |  | IF UNDER 1 YR.<br>MONTHS DAYS HOURS MIN   |  | IF UNDER 24 HRS.  |  | 21. DATE PRONOUNCED DEAD<br>12 8 19 79  |   |  |  |  |  |  |  |                       |  | 24. HOUR<br>A M |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Md.  |  |                  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  |   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |   |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City, MD.                         |   |  |  |  |  |  |  |                       |  |                 |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore  |  |                  |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Baltimore City Hospital |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>hostess  |  |   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Hausner  |   |  |  |  |  |  |  |                       |  |                 |  |
| 13a. STATE<br>Md.   |  |                  |  | 13b. COUNTY<br>Balto.   |  | 13c. CITY OR TOWN<br>Balto.                               |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 13e. STREET ADDRESS<br>144 S. Bouldin Street  |  |   |   |  |  |  |  |  |  |                       |  |                 |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Glyn Lewis  |  |                  |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Eva Kane |  |   |  |   |  |   |   |  |  |  |  |  |  |                       |  |                 |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br>no   |  |                  |  | 16b. SOCIAL SECURITY NO.  |  | 17. INFORMANT ADDRESS<br>Mr. Jack Pfeifer, 144 S. Bouldin |  |   |  |   |  |   |   |  |  |  |  |  |  |                       |  |                 |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a). <u>Carcinomatosis, primary not found</u><br>1990<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>DUE TO, OR AS A CONSEQUENCE OF  |  |                  |  |   |  |   |  |   |  |   |  |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |  |  |  |  |                       |  |                 |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).   |  |                  |  |   |  |   |  |   |  |   |  |   |   |  |  |  |  |  |  |                       |  |                 |  |
| 19a. DATE OF OPERATION  |  |                  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |  |   |  |   |  |   |  | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   |  |  |  |  |  |  |                       |  |                 |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |  |                  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)   |  |   |  |   |   |  |  |  |  |  |  |                       |  |                 |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK   |  |                  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)   |  |   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |   |   |  |  |  |  |  |  |                       |  |                 |  |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . |  |                  |  |   |  |   |  |   |  |   |  |   |   |  |  |  |  |  |  |                       |  |                 |  |
| ACTUAL SIGNATURE<br><u>Virginia L. Dolan M.D.</u>   |  |                  |  | TITLE (SPECIFY)<br>Assistant  |  |   |  | MEDICAL EXAMINER  |  |   |  | DATE SIGNED<br>12/8/79  |   |  |  |  |  |  |  |                       |  |                 |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT)<br>Virginia L. Dolan, M.D.   |  |                  |  | ADDRESS<br>111 Penn Street  |  |   |  |   |  |   |  |   |   |  |  |  |  |  |  |                       |  |                 |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial  |  |                  |  | 23b. DATE<br>12/11/79   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Sacred Heart        |  |   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore, Md.  |  |   |   |  |  |  |  |  |  |                       |  |                 |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br>Zannino Funeral Home, 263 S. Conkling St  |  |                  |  |   |  |   |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br>DEC 10 1979  |  |   | 25b. REGISTRAR'S SIGNATURE<br><u>Anthony M. Brady</u> |  |  |  |  |  |  |                       |  |                 |  |





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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

7 9 30511

FOR  
1 - STATE  
REGISTRAR

|  |  |   |  |   |  |  |   |  |   |  |
|--|--|---|--|---|--|--|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>DANIEL F. PFENNING</b>   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>12-10-79</b>                 |   |  | 2b. HOUR<br>M.   |   |  |   |  |
| 3. SEX<br><b>M</b>   |  | 4. RACE<br><b>W</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>7 5 1911</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>68</b> YRS.  |   | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.   |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MARYLAND</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.  |   |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTO.</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>20 S. CHESTER ST.</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>CHAFFEUR</b>  |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>TAXI</b>   |   |  |
| 13a. STATE<br><b>MD.</b>   |  |   | 13b. COUNTY<br><b>-</b>  |   | 13c. CITY OR TOWN<br><b>BALTO.</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>20 S. CHESTER ST.</b> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>DANIEL PFENNING</b>   |  |   |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>CLARA</b>                  |  |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>  |  |   | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>-</b>    |   | 17. INFORMANT<br>ADDRESS<br><b>Mrs. Elizabeth Chmura - 2913 Inglewood Ave.</b> |  |   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a): <b>ARTERIOSCLEROTIC CARDIO-VASC. DISEASE</b><br><b>4292</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>8 years</b> |  |   |  |   |  |  |   |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><b>DIABETES MELLITUS</b>  |  |   |  |   |  |  |   |  |   |  |
| 19a. DATE OF OPERATION   |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>      |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |   |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |  |   |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>11/1/79</b> , 19 <b>79</b> , to <b>12/10</b> , 19 <b>79</b> , that (I) (we) lost <b>now the deceased alive on 11/5/79</b> , 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated <b>showing I did not view the body after death.</b>   |  |   |  |   |  |  |   |  |   |  |
| 22b. SIGNATURE<br><b>Irvin B. Kaplan</b>   |  |   | DEGREE<br><b>MD</b>  |   |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |   | 22c. DATE SIGNED<br><b>12/15/79</b>  |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>IRVIN B. KAPLAN, MD</b>  |  |   | 22e. ADDRESS<br><b>129 S. BROADWAY 21231</b>                           |   |  |  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>BURIAL</b>   |  |   | 23b. DATE<br><b>12-14-1979</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>MT. CARMEL CEMETERY</b>               |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>BALTO. MD.</b>                                 |  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Stanley Miller 7527 Harvard Rd.</b>   |  |   | 25a. DATE REC'D. BY REGISTRAR<br><b>DEC 17 1979</b>                    |   | 25b. REGISTRAR'S SIGNATURE<br><b>Stanley Miller</b>                            |  |   |  |   |  |

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon-joggers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 1 retained by the hospital or attending physician.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  |   |  |  |   |  |  |  |
|--|--|---|--|---|--|--|---|--|--|--|
| 1- FOR STATE REGISTRAR   |  |   |  |   | 7 9 3 0 5 1 2<br>REG. NO.  |  |   |  |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>JAMES G. PHILLIPS</b>  |  |   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>12/19/79</b>                 |  |   | 2b. HOUR<br><b>1:30</b> M  |  |  |
| 3. SEX<br><b>Male</b>  |  | 4. RACE<br><b>White</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>August 20, 1884</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>95</b>   |   | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.<br>IF UNDER 24 HRS   |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Pennsylvania</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.  |   |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>UNION MEMORIAL HOSPITAL</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Lawyer</b>  |   | 12b. KIND OF BUSINESS OR INDUSTRY  |  |  |
| 13a. STATE<br><b>Maryland</b>  |  |   | 13b. COUNTY  |   | 13c. CITY OR TOWN<br><b>Baltimore</b>                                  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>3501 St. Paul Street</b> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>George Phillips</b>   |  |   |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE<br><b>Elizabeth Hildebran</b> |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>No</b>  |  |   | 16b. SOCIAL SECURITY NO.<br><b>220-44-0126</b>                         |   | 17. INFORMANT ADDRESS<br><b>Bruce H. Chilcote 1304 McPherson Court</b> |  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Prostatic Carcinoma</b><br><b>1832</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>DUE TO, OR AS A CONSEQUENCE OF |  |   |  |   |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH       |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |   |  |   |  |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>19</b>           |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>12/13</b> 19 <b>79</b> , to <b>12/19</b> 19 <b>79</b> , that (I) (we) last saw the deceased alive on <b>12/19</b> 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.            |  |   |  |   |  |  |   |  |  |  |
| 22b. SIGNATURE<br><b>Benjamin K. Yorkoff, MD</b>   |  |   |  |   |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |   | 22c. DATE SIGNED<br><b>12/19/79</b>  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Yorkoff</b>  |  |   |  |   |  | 22e. ADDRESS<br><b>UNION MEMORIAL HOSPITAL</b>   |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |  |   | 23b. DATE<br><b>12-21-1979</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Loudon Park</b>               |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Maryland</b>                         |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Ruck Towson Funeral Home, Inc. Towson, Maryland</b>   |  |   |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>DEC 21 1979</b>  |   | 25b. REGISTRAR'S SIGNATURE<br><i>R. J. Hildebran</i>   |  |  |

STUDY MONITORING

ANALYSIS OF DATA

ANALYSIS OF DATA

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

5

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

79 30513

|  |  |   |  |  |  |   |   |  |  |                                     |  |
|--|--|---|--|--|--|---|---|--|--|-------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>KENNETH Roeper PHILLIPS</b>  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>12/8 79</b>                  |  |  | 2b. HOUR<br><b>4:30 am</b>  |   |  |  |                                     |  |
| 3 SEX<br><b>Male</b>   |  | 4 RACE<br><b>White</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Nov. 1, 1910</b>  |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br><b>69</b> YRS.  |   | 7. IF UNDER 1 YEAR<br>MONTHS DAYS<br><b>69</b>   |  |                                     |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>New York</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.                          |   |  |  |                                     |  |
| 10 CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>UNION MEMORIAL HOSPITAL</b> |  |  |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Claims Manager</b> |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Transportation</b>   |  |                                     |  |
| 13a. STATE<br><b>Maryland</b>  |  |   | 13b. COUNTY<br><b>Baltimore</b>  |  | 13c. CITY OR TOWN<br><b>Jarrettsville</b>                      |   | 13d. INSIDE CITY LIMITS?<br><input type="checkbox"/> NO <input checked="" type="checkbox"/> YES |  | 13e. STREET ADDRESS<br><b>4155 Madonna Road</b>                          |                                     |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>George Featherly Phillips</b>   |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Emma Roeper</b>    |  |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>Yes</b>        |   |  |  |                                     |  |
| 16b. SOCIAL SECURITY NO.<br><b>W.W. 11</b>   |  |   | 17 INFORMANT<br><b>Annette E. Phillips</b>                             |  |  | ADDRESS<br><b>21084 4155 Madonna Road</b>   |   |  |  |                                     |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Sw Pneumonia</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>sepsis</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>10389</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.                    |  |   |  |  |  |   |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>1wk</b><br><b>1wk</b> |                                     |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |   |  |  |  |   |   |  |  |                                     |  |
| 19a. DATE OF OPERATION   |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>      |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                 |  |                                     |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>      |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)            |   |  |  |                                     |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |  |  |                                     |  |
| 22a. I certify that (this hospital) attended the deceased from <b>12/15</b> , 19 <b>79</b> , to <b>12/17/79</b> , 19 <b>79</b> , that (he)-(we) lost<br>saw the deceased alive on <b>12/18</b> , 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above. (If true) (If not, did not view the body after death). |  |   |  |  |  |   |   |  |  |                                     |  |
| 22b. SIGNATURE<br><b>Steve 1221 MD</b>   |  |   |  |  |  | DEGREE<br><b>MD</b>   |   | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br><b>12/17/79</b> |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Steve 1221 MD</b>  |  |   |  |  |  | 22e. ADDRESS<br><b>UNION MEMORIAL HOSPITAL</b>  |   |  |  |                                     |  |
| 23a. BURIAL, CREMATION, REMOVAL<br><b>Cremation</b>  |  |   | 23b. DATE<br><b>Dec. 19, '79</b>                                       |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Westview Mem. Pk.</b> |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Balto. Co., Md.</b>                            |  |  |                                     |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>William E. Johnson</b>  |  |   |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>DEC 19 1979</b>                                       |   | 25b. REGISTRAR'S SIGNATURE<br><b>Patricia Helms</b>  |  |                                     |  |

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DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

7 9 3 0 5 1 4

1. FOR  
STATE  
REGISTRAR1. DECEASED NAME  
(TYPE OR PRINT)

FIRST

MIDDLE

LAST

Samuel N. Phillips

2a. DATE OF DEATH MONTH DAY YEAR

12 15 79

2b. HOUR

M

3. SEX

Male

4. RACE

Black

5. DATE OF BIRTH

09 22 1913

6. AGE (IN YEARS LAST BIRTHDAY)

66

IF UNDER 1 YEAR

IF UNDER 24 HRS

MONTHS

DAYS

HOURS

MIN

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)

Alabama

7b. CITIZEN OF WHAT COUNTRY?

U.S.A.

8. MARRIED ☒ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH

Baltimore City

MD.

10. CITY OR TOWN OF DEATH

Baltimore

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)

2004 N. Bentalou Street

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)

Principal

12b. KIND OF BUSINESS OR INDUSTRY

City Sch-System

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE Maryland

13b. COUNTY

13c. CITY OR TOWN Baltimore

13d. INSIDE CITY LIMITS?

YES ☒ NO ☐

13e. STREET ADDRESS

2004 N. Bentalou Street

14. FATHER'S NAME

William

MIDDLE

W.

Phillips

15. MOTHER'S MAIDEN NAME

Eugenia

MIDDLE

Nixon

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)

YES

16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)

WWII

17. INFORMANT

214-40-4591

ADDRESS

Bentalou St. Mrs. Gloria M. Phillips 2004 N.

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  
PART 1: DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Myocardial Infarction

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

Small

410-

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b)

Coronary Heart Failure

DUE TO, OR AS A CONSEQUENCE OF

(c)

Fatty Metamorphosis of the Liver

PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY?

YES ☐ NO ☒

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?

YES ☐ NO ☐21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21d. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION STREET

CITY OR TOWN

COUNTY

STATE

22a. I certify that (I) (the hospital) attended the deceased from 1970, to Dec 1979, that (I) (we) lost saw the deceased alive on Nov 22 1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE

Simon H. Carter M.D.

DEGREE

ATTENDING PHYSICIAN ☒MEDICAL DIRECTOR ☐STAFF PHYSICIAN ☐

22c. DATE SIGNED

17 Dec 79

22d. PHYSICIAN'S NAME (TYPE OR PRINT)

Dr. Simon Carter M.D.

22e. ADDRESS

4432 Park Hgts Dr

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)

Burial

23b. DATE

12-19-79

23c. NAME OF CEMETERY OR CREMATORY

Arbutus Mem. Pk.

23d. LOCATION CITY OR TOWN

Balto. County Maryland

STATE

24. FUNERAL DIRECTOR NAME

Herbert E. Nutter 3035 W. NORTH AVE.

ADDRESS

25a. DATE REC'D. BY REGISTRAR

DEC 17 1979

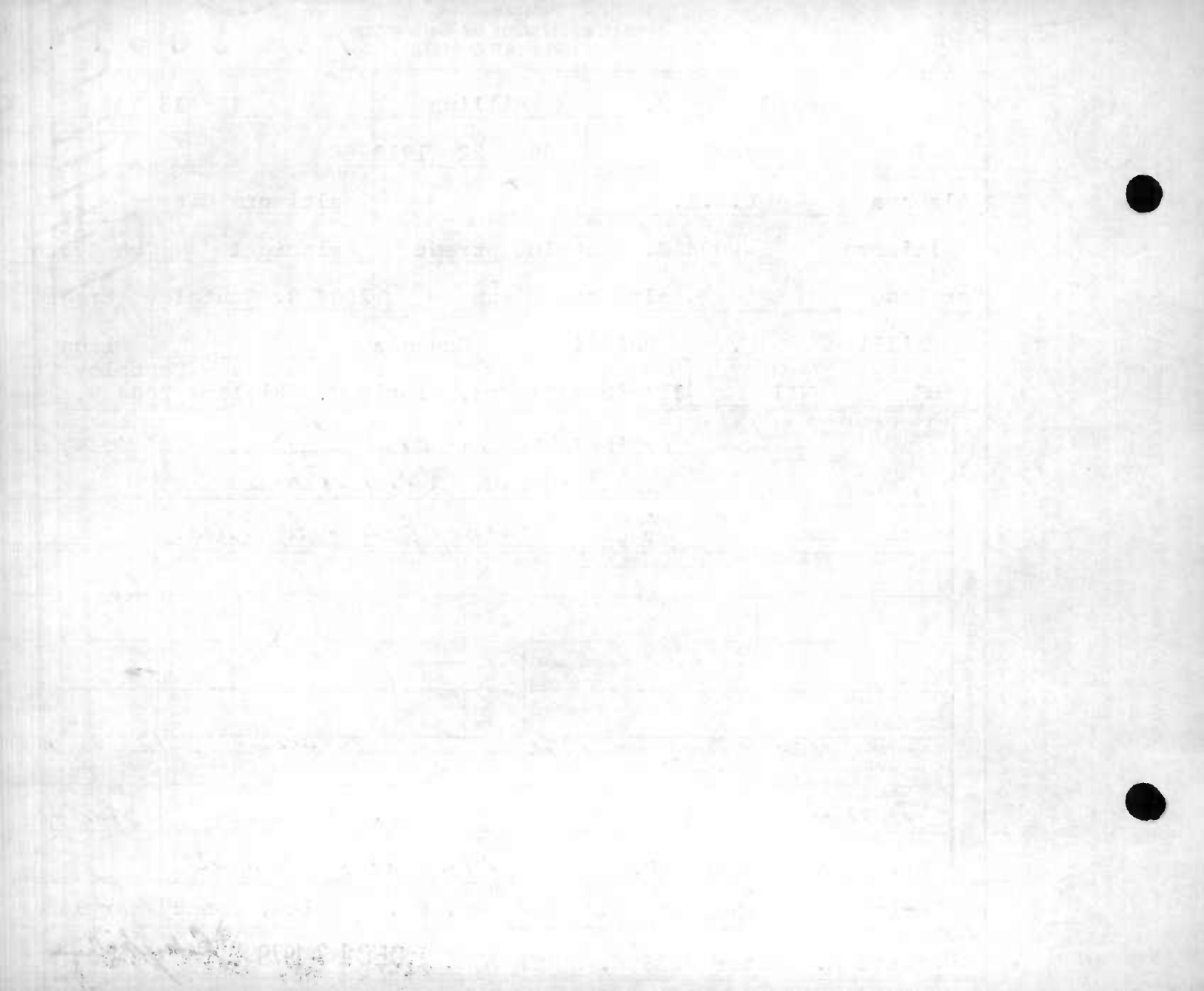
25b. REGISTRAR'S SIGNATURE

Simon H. Carter

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.





3

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed without delay with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at 335-1703.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  |   |  |  |  |   |  |  |  |
|--|--|---|--|---|--|--|--|---|--|--|--|
| 1. FOR STATE REGISTRAR   |  | 79  |  | 30515   |  | REG. NO.   |  |   |  |  |  |
| 1. DECEASED NAME (TYPE OR PRINT)   |  | FIRST   |  | MIDDLE  |  | LAST   |  | 2a. DATE OF DEATH   |  | 2b. HOUR                                     |  |
| ETTA   |  | B   |  | P   |  | INN  |  | 12-29-79  |  | 730 PM                                       |  |
| 3. SEX   |  | 4. RACE   |  | 5. DATE OF BIRTH  |  | 6. AGE (IN YEARS LAST BIRTHDAY)                                |  | 7. IF UNDER 1 YEAR  |  | 8. IF UNDER 24 HRS                           |  |
| FEMALE   |  | NORW  |  | 10 28 90  |  | 89   |  | MONTHS  |  | DAYS   |  |
| 9a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  | 9b. CITIZEN OF WHAT COUNTRY?  |  | 10. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 11. BALTIMORE CITY OR COUNTY OF DEATH                          |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) |  | 12b. KIND OF BUSINESS OR INDUSTRY            |  |
| BALTIMORE MD   |  | USA   |  |   |  | BALTIMORE CITY   |  | HOSPITAL  |  |  |  |
| 13a. CITY OR TOWN OF DEATH   |  | 13b. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 13c. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  | 13d. INSIDE CITY LIMITS?                                       |  | 13e. STREET ADDRESS   |  | 13f. CITY OR TOWN                            |  |
| BALTIMORE  |  | GREATER P.A. HOSPITAL   |  | MD  |  | YES <input type="checkbox"/> NO <input type="checkbox"/>       |  | 1126 MYNOLD AVE   |  |  |  |
| 14. FATHER'S NAME  |  | 15. MOTHER'S MAIDEN NAME  |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)   |  | 16b. SOCIAL SECURITY NO.                                       |  | 17. INFORMANT   |  | ADDRESS                                      |  |
| Gordon L. Boyan  |  | Mary E. Boyan   |  | NO  |  |  |  | Harvey Gordon   |  | 2635 Raymon Ave                              |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |  |   |  |   |  |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART I. DEATH WAS CAUSED BY:   |  |   |  |   |  |  |  |   |  |  |  |
| IMMEDIATE CAUSE (a) Old Stroke, Right Hemiplegia   |  |   |  |   |  |  |  |   |  |  |  |
| 436- DUE TO, OR AS A CONSEQUENCE OF  |  |   |  |   |  |  |  |   |  |  |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.   |  |   |  |   |  |  |  |   |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF   |  |   |  |   |  |  |  |   |  |  |  |
| (c)  |  |   |  |   |  |  |  |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |   |  |   |  |  |  |   |  |  |  |
| Cardiomyopathy Urinary Tract Infection   |  |   |  |   |  |  |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |  |   |  |  |  |
|  |  |   |  | YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | YES <input type="checkbox"/> NO <input type="checkbox"/>       |  |   |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |  |  |  |   |  |  |  |
|  |  | HOUR A.M. MONTH DAY YEAR  |  |   |  |  |  |   |  |  |  |
|  |  | P.M. 19   |  |   |  |  |  |   |  |  |  |
| 21d. INJURY OCCURRED   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                     |  | 21f. LOCATION   |  |  |  |   |  |  |  |
| WHERE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |   |  | STREET  |  | CITY OR TOWN   |  | COUNTY  |  | STATE  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 6-20-1963, to 12-29-1979, that (I) (we) lost saw the deceased alive on 12-29-1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |   |  |   |  |  |  |   |  |  |  |
| 22b. SIGNATURE   |  | DEGREE  |  | 22c. DATE SIGNED  |  |  |  |   |  |  |  |
| Reginald O. Crosley  |  | MD  |  | 12-29-1979  |  |  |  |   |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  | 22e. ADDRESS  |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                |  |  |  |   |  |  |  |
| Reginald O. Crosley  |  | 1235 E. Monument Street   |  |   |  |  |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (TYPE IF)  |  | 23b. DATE   |  | 23c. NAME OF CEMETERY OR CREMATORY  |  | 23d. LOCATION  |  |   |  |  |  |
| Burial   |  | 1/4/79  |  | Mt Auburn   |  | BALTIMORE MD   |  |   |  |  |  |
| 24. FUNERAL DIRECTOR   |  | 24b. ADDRESS  |  | 25a. DATE REC'D. BY REGISTRAR   |  | 25b. REGISTRAR'S SIGNATURE                                     |  |   |  |  |  |
| M.P. Hines   |  | 238 N. 7th St   |  | JAN 2 1980  |  | Ruthy Anthony  |  |   |  |  |  |



Don't be too sure of your ground.

Remember, the only way to win is to win.

And the only way to win is to win.

Remember, the only way to win is to win.

Remember, the only way to win is to win.

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Remember, the only way to win is to win.

Remember, the only way to win is to win.

Remember, the only way to win is to win.

CMC/4 0 150 13 79

BP

DHMH-16 50M 7/77  
(VR A 15 (4))

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be signed by the attending physician within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be completely filled in by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  | 7 9 3 0 5 1 6<br>REG. NO.   |  |  |  |
|---|--|---|--|---|--|--|--|
| 1. FOR STATE REGISTRAR  |  |   |  | 2a. DATE OF DEATH   |  |  |  |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br>SAUNDRA L. PITT   |  |   |  | MONTH DAY YEAR<br>12 15 79  |  | 2b. HOUR<br>5:32 PM  |  |
| 3. SEX<br>Female  |  | 4. RACE<br>White  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>May 2, 1972   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>7<br>YRS MONTHS DAYS HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN)<br>Maryland   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD.   |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>THE JOHNS HOPKINS HOSPITAL |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>-   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>-   |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |   |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |  |  |
| 13a. STATE<br>Maryland  |  | 13b. COUNTY<br>Harford  |  | 13c. CITY OR TOWN<br>Forest Hill  |  | 13e. STREET ADDRESS<br>109 Bynum Rd. 21050   |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>Warren H. Pitt, Jr.  |  |   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Lucy M. Guthrie   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) No   |  | 16b. SOCIAL SECURITY NO.<br>212-94-1324   |  | 17. INFORMANT ADDRESS<br>Warren Pitt, Jr., father-same address  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>RESPIRATORY FAILURE</u><br>2770<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>CYSTIC FIBROSIS</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.                |  |   |  |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |
| 22a. I certify that (I) (the hospital) attended the deceased from <u>12/3</u> , 19 <u>79</u> , to <u>12/15</u> , 19 <u>79</u> , that (I) <del>lost</del> saw the deceased alive on <u>12/15</u> , 19 <u>79</u> , and that in (my) <del>best</del> opinion death occurred on the date and hour and from the causes stated above. (I) <del>will</del> (did) <del>not</del> view the body after death. |  |   |  |   |  |  |  |
| 22b. SIGNATURE<br><i>John W. Bender</i>   |  |   |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>        |  | 22c. DATE SIGNED<br>12/15/79   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>JOHN W. BENDER MD  |  |   |  | 22e. ADDRESS<br>JOHNS HOPKINS HOSPITAL BALTIMORE  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial   |  | 23b. DATE<br>19 Dec. 79   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Parkwood Cemetery   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore, Md.   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Schlunberg Funeral Home, Inc.   |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br>2705 Belair Rd. Balto., Md. 21236<br>DEC 18 1979   |  | 25b. REGISTRAR'S SIGNATURE<br><i>Harvey McCreedy</i>   |  |

PC 61 021 0 4/CMJ

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  |   |  |   |                                       |  |   |  |
|--|--|--|--|---|--|---|---------------------------------------|--|---|--|
| 1. FOR<br>STATE<br>REGISTRAR   |  | 7 9 3 0 5 1 7<br>REG. NO. <i>62202</i>   |  |   |  |   |                                       |  |   |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Andrew (Henry) Piwinski</b>   |  |  |  |   | 2a. DATE OF DEATH<br>(MONTH DAY YEAR) <b>12-14-79</b>                      |   | 2b. HOUR<br><b>7:25 P.M.</b>          |  |   |  |
| 3. SEX<br><b>Male</b>  |  | 4. RACE<br><b>White</b>  |  | 5. DATE OF BIRTH<br>(MONTH DAY YEAR) <b>11 07 90</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>89</b> YRS.   |                                       | 7. IF UNDER 1 YEAR<br>MONTHS DAYS  |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Balt. Md.</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.   |                                       |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Balt. City</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Mercy Hospital, Inc.</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Foreman Retired Langrall Cannery</b> |                                       | 12b. KIND OF BUSINESS OR INDUSTRY  |   |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE <b>Maryland</b>  |  |  |  |   | 13b. COUNTY  |   | 13c. CITY OR TOWN<br><b>Baltimore</b> |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Lawrence Piwinski</b>   |  |  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Katherine Urbanski</b> |   |                                       |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>216-01-4698-A</b>   |  | 17. INFORMANT<br>ADDRESS<br><b>Ms. Maryann Czawlytko, 604 S. Wolfe St. 21231</b>  |  |   |                                       |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Pulmonary infarcts, left lung.</b><br>4140<br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>ASD &amp; aortic proliferation.</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>chronic congestive heart failure &amp; peripheral vascular disease.</b><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>1-2 days.</b><br><b>years.</b> |  |  |  |   |  |   |                                       |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><b>Small perforate polyps.</b>  |  |  |  |   |  |   |                                       |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                        |                                       | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |                                       |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |                                       |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |  |  |   |  |   |                                       |  |   |  |
| 22b. SIGNATURE<br><i>A. Walsch</i>   |  |  |  | DEGREE  |  |   |                                       | 22c. DATE SIGNED<br><b>12/15/79</b>  |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  |  |  | 22e. ADDRESS  |  |   |                                       |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>Dec. 18, 1979</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>St. Stanislaus Cemetery</b>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore, Maryland</b>                                    |                                       |  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>M.F. Sadowski &amp; Sons, 1808 Eastern Avenue 21231</b>   |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>DEC 17 1979</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><i>P. J. H. H. H.</i>   |                                       |  |   |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of the death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the informant, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Item 7b g539 1/14/80 gj

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

7 9 3 0 5 1 8

REG. NO.

|   |  |   |  |   |  |   |                                       |   |   |  |
|---|--|---|--|---|--|---|---------------------------------------|---|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>- Charles</b>   |  | FIRST<br><b>POLESKI</b>   |  | LAST  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>December 30, 1979</b>                         |                                       | 2b. HOUR<br><b>3:00A</b> M  |   |  |
| 3. SEX<br><b>Male</b>   |  | 4. RACE<br><b>White</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>May 12, 1903</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>76</b> YRS.                                       |                                       | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN<br>IF UNDER 24 HRS<br>HOURS MIN  |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Yugoslavia</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>Yugoslavia</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore</b> MD.                            |                                       |   |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Church Hospital Corp.</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Steel worker</b> |                                       | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Armco Steel</b>   |   |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>Maryland</b>  |  |   |  |   | 13b. COUNTY<br><b>--</b>   |   | 13c. CITY OR TOWN<br><b>Baltimore</b> |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Michael -- Poleski</b>   |  |   |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Anna -- Sinozich</b> |   |                                       |   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>   |  |   | 16b. SOCIAL SECURITY NO<br>(IF YES, GIVE WAR OR DATES)<br><b>223-05-2061</b> |   | 17. INFORMANT<br>ADDRESS<br><b>Mary Poleski 1736 Lancaster St.</b>       |   |                                       |   |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY.<br>IMMEDIATE CAUSE (a) <b>Cardiopulmonary arrest of few hours duration</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Congestive heart failure, Pulmonary edema</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Renal shutdown</b>       |  |   |  |   |  |   |                                       | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH   |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).  |  |   |  |   |  |   |                                       |   |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>               |                                       | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |  |   |                                       |   |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |                                       |   |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>Dec. 9, 1979</b> to <b>Dec. 30, 1979</b> , that (I) (we) lost<br>saw the deceased alive on <b>Dec. 30, 1979</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death. |  |   |  |   |  |   |                                       |   |   |  |
| 22b. SIGNATURE<br><b>Fahim Khorfan</b>  |  | DEGREE<br><b>MD</b>   |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>                  |  |   |                                       | 22c. DATE SIGNED<br><b>12/30/79</b>   |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Fahim Khorfan</b>   |  |   |  | 22e. ADDRESS<br><b>1711 Hampshire Green Lane Apt #21<br/>Silver Spring MD 20903</b>   |  |   |                                       |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>Jan. 2, 1980</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>St. Stanislaus Cem.</b>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore -- Maryland</b>              |                                       |   |   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Lilly &amp; Zeiler Inc. 1901 Eastern Ave. 21231</b>  |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JAN 2 1980</b>  |  | 25b. SIGNATURE<br><b>[Signature]</b>  |                                       |   |   |  |



01000 71

15 NOV 1954



0001

1412

*[Handwritten signature]*



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING," IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 48 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |  |                                       |  |   |   |   |  |   |   | REG. NO. 30519  |  |
|--|--|---------------------------------------|--|---|---|---|--|---|---|---|--|
| 1. FOR STATE REGISTRAR   |  |                                       |  |   |   |   |  |   |   |   |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) FIRST MIDDLE LAST<br><b>Vinson Stewart Poling</b>  |  |                                       |  |   |   |   |  |   |   | 2a. DATE KNOWN OF DEATH<br>ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR<br><b>12 4 1979</b> |  |
| 3. SEX<br><b>male</b>  |  | 4. RACE<br><b>white</b>               |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Jan 28, 1923</b>                                       |   | 6. AGE (IN YEARS)<br>LAST BIRTHDAY YRS.<br><b>56</b>  |  | IF UNDER 1 YR.<br>MONTHS DAYS<br><b>XX</b>                              |   | 2b. DATE PRONOUNCED DEAD<br>MONTH DAY YEAR<br><b>12 4 1979</b>  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>West Virginia</b>  |  |                                       | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |   |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |  |                                       | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Good Samaritan Hospital</b> |   |   |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Metal Plater</b> |   |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>G.L. Martin</b>   |  |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |                                       |  |   |   |   |  |   |   |   |  |
| 13a. STATE<br><b>Maryland</b>  |  | 13b. CITY OR TOWN<br><b>Baltimore</b> |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   | 13e. STREET ADDRESS<br><b>3708 Raspe Avenue</b>   |  |   |   |   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Silas Poling</b>  |  |                                       |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Lihla</b> |   |  |   |   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>Yes WW 2</b>   |  |                                       |  | 16b. SOCIAL SECURITY NO.<br><b>233-30-6062</b>  |   | 17. INFORMANT ADDRESS<br><b>Lillian C. Poling 3708 Raspe Ave 21206</b>  |  |   |   |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Arteriosclerotic cardiovascular disease</b><br>4292<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>DUE TO, OR AS A CONSEQUENCE OF  |  |                                       |  |   |   |   |  |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).  |  |                                       |  |   |   |   |  |   |   |   |  |
| 19a. DATE OF OPERATION   |  |                                       |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |   |   |  |   |   | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                         |  |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |  |                                       |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                      |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |  |   |   |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  |                                       |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)                                     |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |   |   |  |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |  |                                       |  |   |   |   |  |   |   |   |  |
| ACTUAL SIGNATURE<br><i>H. Guard</i>  |  |                                       |  | TITLE (SPECIFY)<br><b>Assistant</b>   |   |   |  | DATE SIGNED<br><b>12/5/79</b>   |   |   |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT)<br><b>Hormez R. Guard, M.D.</b>   |  |                                       |  | ADDRESS<br><b>111 Penn Street, Balto., MD 21201</b>   |   |   |  |   |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |  |                                       |  | 23b. DATE<br><b>Dec. 7, 79</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Gardens of Faith Cem.</b>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Co., Md.</b> |   |   |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Dippel Brothers, Inc. 7110 Belair Rd. 21206</b>   |  |                                       |  |   |   | 25a. DATE REC'D. BY REGISTRAR<br><b>DEC 7 1979</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><i>Henry M. Brady</i>                     |   |   |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use in the burial transit permit. Then please affix carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  |   |   |  |  |  |  |   |  |
|---|--|---|--|---|---|--|--|--|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>THOMAS POLK</b>  |  |   |  |   | 2a. DATE OF DEATH MONTH DAY YEAR <b>12-1-79</b> |  |  |  |  | 2b. HOUR <b>945A</b> M  |  |
| 3. SEX <b>Male</b>  |  | 4. RACE <b>Black</b>  |  | 5. DATE OF BIRTH MONTH DAY YEAR <b>10 24 1903</b>   |   | 6. AGE IN YEARS LAST BIRTHDAY <b>78</b> YRS  |  | IF UNDER 1 YEAR MONTHS DAYS  |  | IF UNDER 24 HRS. HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>North Carolina</b>   |  | 7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>   |   | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>Balti. City</b> MD.                                  |  |  |  |   |  |
| 10. CITY OR TOWN OF DEATH <b>City</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Lutheran Hosp.</b> |  |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Retired</b>              |  | 12b. KIND OF BUSINESS OR INDUSTRY <b>None</b>                          |  |   |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE <b>MD.</b>   |  | 13b. COUNTY   |  | 13c. CITY OR TOWN <b>Balti. City</b>  |   | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS <b>3513 Kaplan St</b>                              |  |   |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST <b>Richard Covington</b>  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Lillie Lowery</b>   |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>NO</b>  |   | 16b. SOCIAL SECURITY NO. <b>21205-9152</b>   |  | 16c. INFORMANT ADDRESS <b>NEILL JACKSON<br/>3202 DOYERSON CT.</b>      |  |   |  |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c):<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CARDIORESPIRATORY ARREST.</b><br><b>1532</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:<br>(b) <b>EMPHYSEMA LUNGS.</b><br>(c) <b>CANCER LEFT COLON.</b>                |  |   |  |   |   |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |   |  |   |   |  |  |  |  |   |  |
| 19a. DATE OF OPERATION  |  |   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   |  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)               |  |  |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |   | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>11-2-</b> 19 <b>78</b> , to <b>12-1-</b> 19 <b>79</b> , that (I) (we) last saw the deceased alive on <b>12-1-</b> 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |   |  |   |   |  |  |  |  |   |  |
| 22b. SIGNATURE <b>Arnell E. Burgess</b>   |  |   |  | DEGREE <b>M.D.</b> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |   |  |  | 22c. DATE SIGNED <b>12-1-79</b>  |  |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Arnell E. Burgess</b>  |  |   |  | 22e. ADDRESS <b>5010 York Rd BALD. MD 21244</b>   |   |  |  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>   |  | 23b. DATE <b>12/4/1979</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY <b>King Memorial Park</b>  |   |  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore Co. Maryland</b>  |  |   |  |
| 24. FUNERAL DIRECTOR NAME <b>Wm. C. March F/H</b>   |  |   |  | ADDRESS <b>1101 East North Avenue</b>   |   |  |  | 25a. DATE REC'D. BY REGISTRAR <b>DEC 3 1979</b>                        |  | 25b. REGISTRAR'S SIGNATURE <b>Robert J. Brady</b>   |  |

U.S. GOVERNMENT

THOMAS S. A. 2479017



U.S. GOVERNMENT  
PRINTING OFFICE  
WASHINGTON, D.C.

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U.S. GOVERNMENT  
PRINTING OFFICE  
WASHINGTON, D.C.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Please may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be completely filled in by the funeral director. It should be detached for use as a death certificate. Then, make remove carbon 1, 2 and 3. Carbon 1 should be retained by the funeral director. Carbon 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial or cremation. Carbon 3 should be retained by the funeral director.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |   |  |   |  |   |   |   |
|--|--|--|---|--|---|--|---|---|---|
| 1- FOR STATE REGISTRAR   |  |  |   |  |   |  |   |   |   |
| 1 DECEASED NAME (TYPE OR PRINT)<br>ELIZABETH Louise POOLE  |  |  |   |  | 2a DATE OF DEATH<br>MONTH DAY YEAR<br>DECEMBER 27, 1979   |  |   | 2b HOUR<br>1:03 PM  |   |
| 3 SEX<br>Female  |  | 4 RACE<br>White  |   | 5 DATE OF BIRTH<br>MONTH DAY YEAR<br>4 17 1968   |   | 6 AGE (IN YEARS LAST BIRTHDAY)<br>11 YRS   |   | 7a IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN   |   |
| 7b BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland   |  | 7c CITIZEN OF WHAT COUNTRY?<br>USA   |   | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9 BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD                                       |   |   |   |
| 10 CITY OR TOWN OF DEATH<br>Baltimore  |  | 11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>THE JOHNS HOPKINS HOSPITAL |   |  |   | 12a USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Student                     |   | 12b KIND OF BUSINESS OR INDUSTRY<br>---   |   |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  |  |   |  |   |  |   |   |   |
| 13a STATE<br>Md.   |  | 13b COUNTY<br>Balto.   |   | 13c CITY OR TOWN<br>Baldwin  |   | 13d INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 13e STREET ADDRESS<br>21013<br>14005 Quinn Lane, Baldwin, Md  |   |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br>Preston Elliott Poole   |  |  |   |  | 15 MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Ember Louise Williams   |  |   |   |   |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No  |  |  |   | 16b SOCIAL SECURITY NO<br>(IF YES, GIVE WAR OR DATES)<br>---   |   | 17 INFORMANT ADDRESS<br>Mrs. Ember L. Poole, 14005 Quinn Lane                                  |   |   |   |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cardio-respiratory arrest</u><br>7473<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Blocked V-P Shunt</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>---</u><br>CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |  |   |  |   |  |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>--- |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |  |   |  |   |  |   |   |   |
| 19a DATE OF OPERATION  |  |  | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  |   | 20a AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |   | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  | 21b TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  |   | 21c HOW INJURY OCCURRED<br>(ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)               |   |   |   |
| 21d INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  |  | 21e PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  |   | 21f LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |   |   |
| 22a I certify that (I) (this hospital) attended the deceased from <u>12/25</u> 19 <u>77</u> to <u>12/27</u> 19 <u>77</u> , that (I) (we) last saw the deceased alive on <u>12/25</u> 19 <u>77</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                                       |  |  |   |  |   |  |   |   |   |
| 22b SIGNATURE<br><u>Ambrose Vallone</u>  |  |  |   |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  |   | 22c DATE SIGNED<br><u>12/27/79</u>  |   |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT)<br><u>Ambrose Vallone</u>   |  |  |   |  | 22e ADDRESS<br><u>V.H. 4</u>  |  |   |   |   |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial   |  |  | 23b DATE<br>12/29/79  |  | 23c NAME OF CEMETERY OR CREMATORY<br>Dulaney Valley Cem.  |  | 23d LOCATION<br>CITY OR TOWN COUNTY STATE<br>Cockeysville, Maryland |   |   |
| 24 FUNERAL DIRECTOR<br>NAME ADDRESS<br>J. E. Lowell Lemmon, 10 W. Padonia Rd.  |  |  |   |  | 25a DATE REC'D. BY REGISTRAR<br>DEC 28 1979   |  | 25b REGISTRAR'S SIGNATURE<br><u>Robert H. H. H.</u>                 |   |   |

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STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

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REG. NO.

1. FOR  
STATE  
REGISTRAR

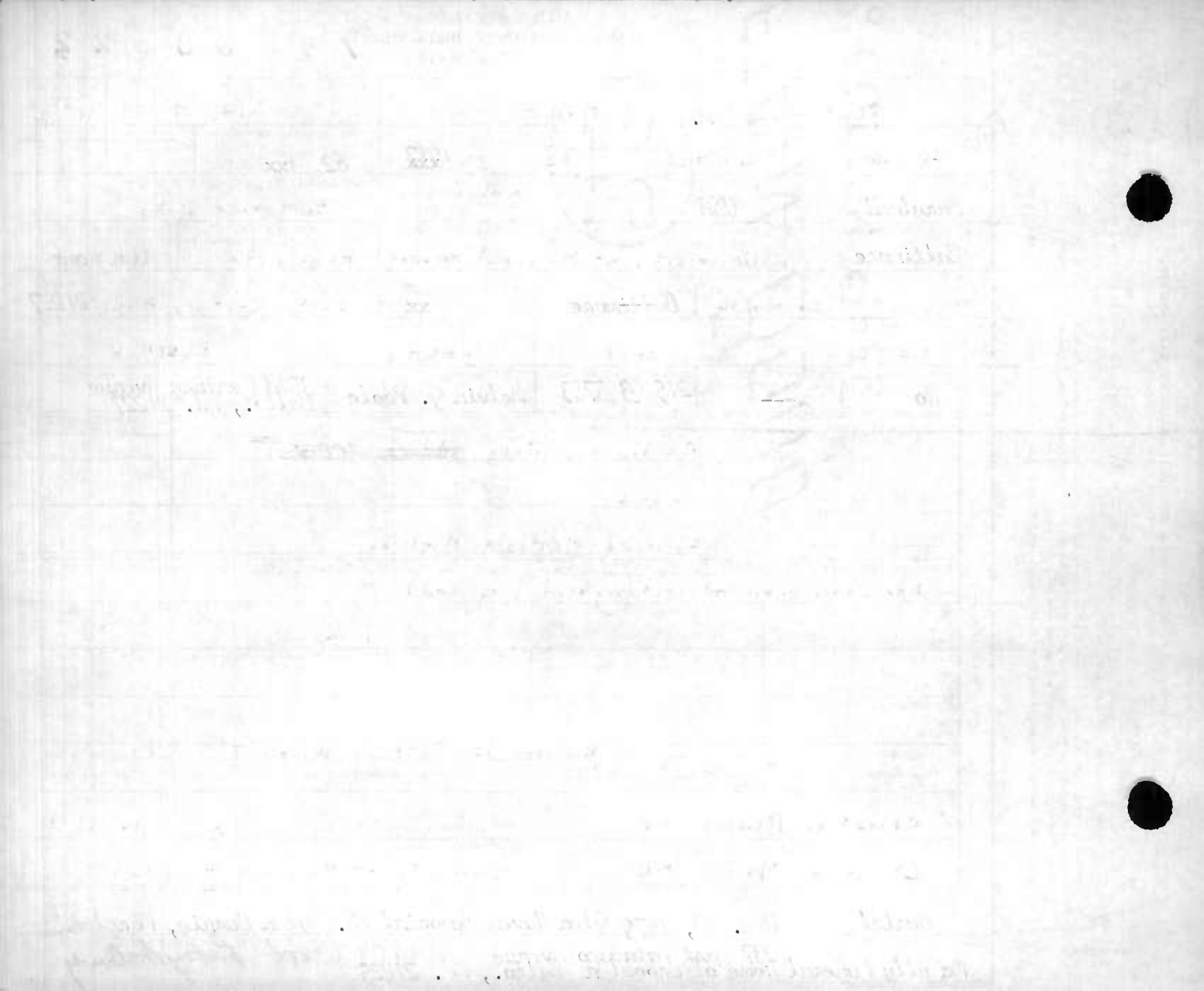
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|--|---|---|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) FIRST MIDDLE LAST<br><b>ROSE M. POOLE</b>  |   |   | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>12 7 79</b>  |  | 2b. HOUR<br><b>11 05 P.M.</b>  |
| 3. SEX<br><b>female</b>  | 4. RACE<br><b>white</b>   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>2 - 13 - 1927</b>  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>62</b> YRS.   |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>   | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.                               |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>University of Maryland Hospital</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Housewife</b>            |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Own Home</b>   |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |   |   |   |  |  |
| 13a. STATE<br><b>Maryland</b>  | 13b. COUNTY<br><b>Baltimore</b>   | 13c. CITY OR TOWN<br><b>Baltimore</b>   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET ADDRESS<br><b>3518 - Century Ave 21227</b>   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>DAVID ZEPP</b>  |   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>LENA RESANCE</b>                            |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>No</b>   |   | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES) <b>215 03 5753</b>  |   | 17. INFORMANT<br><b>Melvin G. Poole</b><br>ADDRESS<br><b>3518 Century Avenue Balto., Md. 21227</b> |  |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardio respiratory arrest</b><br><b>2030</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:<br>(b) <b>Sepsis</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Advanced Multiple Myeloma</b> |   |   |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><b>Adenocarcinoma of rectosigmoid (resected)</b>  |   |   |   |  |  |
| 19a. DATE OF OPERATION   |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>               | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)                     |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>November 12</b> , 19 <b>79</b> , to <b>December 7</b> , 19 <b>79</b> , that (I) (we) lost saw the deceased alive on <b>December 7</b> , 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                            |   |   |   |  |  |
| 22b. SIGNATURE<br><b>Christine Marino, MD.</b>   |   |   |   | 22c. DATE SIGNED<br><b>12/8/79</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Christine Marino, MD.</b>  |   |   |   | 22e. ADDRESS<br><b>University of Maryland Hospital</b>   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |   | 23b. DATE<br><b>Dec. 10, 1979</b>   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Glen Haven Memorial Pk. Glen Burnie, Maryland</b>      |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE   |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>McCully Funeral Home of Brooklyn Balto., Md.</b>  |   | 25. DATE REC'D. BY REGISTRAR<br><b>DEC 11 1979</b>  |   | 26. REGISTRAR'S SIGNATURE<br><b>Robert McBrady</b>   |  |

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 only retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

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REG. NO.

1 - FOR  
STATE  
REGISTRAR

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|--|--|---|---|---|--|--|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Percie I Poulson</b>  |  |   | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>12 25 79</b> |   |  | 2b. HOUR<br><b>8:25 P.M.</b>   |  |   |  |
| 3. SEX<br><b>FEMALE</b>  |  | 4. RACE<br><b>NEGRO</b>   |   | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>3 17 07</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>72</b>   |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.                                 |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>ACCONACLOVA</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City MD.</b>                            |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Providence Hosp</b> |   |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Homemaker at home</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE <b>MD</b> |  |   |   | 13b. COUNTY<br><b>Baltimore</b>   |  | 13c. CITY OR TOWN<br><b>Baltimore</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>ROBERT DRUMMOND</b>   |  |   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Lottie Tylon</b>  |  |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>                                    |  |   |   | 16b. SOCIAL SECURITY NO.  |  | 17. INFORMANT<br>ADDRESS<br><b>Oswald Poulson 2815 Winchester St</b>                         |  |   |  |

|   |  |  |  |
|---|--|--|--|
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Severe Congestive Heart Failure</b> |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH  |  |
| 4380<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost   |  | DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |  |

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):

|   |  |  |  |  |  |  |  |
|---|--|--|--|--|--|--|--|
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost<br>saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |  |  |
| 22b. SIGNATURE<br><b>Winston Hugh Williams MD</b>   |  |  |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br><b>12/25/79</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Winston Hugh Williams MD</b>  |  |  |  | 22e. ADDRESS<br><b>Providence Hospital, Dept of Medicine</b>   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>12/24/79</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>ROBERTS</b>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY<br><b>Baltimore 2227</b>  |  |
| 24. FUNERAL DIRECTOR<br>NAME <b>MR. Days</b> ADDRESS <b>635 N. G. Ave. SP</b>   |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JAN 2 1980</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>Anthony McCreedy</b>  |  |



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |   |  |  |  |   |   |   |  |
|---|--|---|--|--|--|---|---|---|--|
| 1. FOR STATE REGISTRAR  |  |   |  |  | 7 9 3 0 5 2 4  |   |   |   |  |
| 1. DECEASED NAME (TYPE OR PRINT)  |  |   |  |  | 2a. DATE OF DEATH  |   |   |   |  |
| FIRST MIDDLE LAST<br>Powell Alice   |  |   |  |  | MONTH DAY YEAR<br>12 27 79   |   |   |   |  |
| 3 SEX<br>Female   |  | 4 RACE<br>B.K.  |  | 5 DATE OF BIRTH<br>MONTH DAY YEAR<br>1 11 17   |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br>62 YRS.                                     |   | 7b HOUR<br>2 25 P M   |  |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Unkn.   |  | 7b CITIZEN OF WHAT COUNTRY?<br>AMERICA  |  | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD.                    |   |   |  |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>FEDERAL HILL NURSING CENTER |  |  |  | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>WAITRESS      |   | 12b KIND OF BUSINESS OR INDUSTRY<br>RACE TRACK  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |   |  |  | 13d INSIDE CITY LIMITS?  |   |   |   |  |
| 13a STATE<br>Md.  |  | 13b COUNTY  |  | 13c CITY OR TOWN<br>BALTO.   |  | 13d YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>       |   | 13e STREET ADDRESS<br>1651 Mc CATR AVE  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>SAUNDERS DIX  |  |   |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>STEIGISS  |   |   |   |  |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>No  |  |   |  |  | 16b SOCIAL SECURITY NO.<br>212-12-9014   |   | 17 INFORMANT<br>EDNA ROBINSON                                   |   |  |
|   |  |   |  |  | ADDRESS<br>6828 Town Break Dr.   |   |   |   |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Respiratory Arrest</u><br>1749<br>DUE TO, OR AS A CONSEQUENCE OF (b) <u>Metastatic Carcinoma</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF (c) <u>Breast Carcinoma</u> |  |   |  |  |  |   |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH         |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |   |  |  |  |   |   |   |  |
| 19a DATE OF OPERATION   |  |   | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED                    |  |  | 20a AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>      |   | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   | 21b TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19          |  |  | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |   |   |  |
| 21d INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |   | 21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  |  | 21f LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |   |   |  |
| 22a I certify that (I) (this hospital) attended the deceased from <u>4/19</u> , 19 <u>74</u> , to <u>12/27</u> , 19 <u>79</u> , that (I) (we) lost saw the deceased alive on <u>12/27</u> , 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                             |  |   |  |  |  |   |   |   |  |
| 22b SIGNATURE<br>X <u>Marsha Brown</u>  |  |   |  |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |   |   | 22c DATE SIGNED<br>12-29-79   |  |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT)<br><u>DR. MARSHA BROWN</u>   |  |   |  |  | 22e ADDRESS<br>844 N. Carey Ave Baltimore  |   |   |   |  |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial  |  |   | 23b DATE<br>12-31-79   |  | 23c NAME OF CEMETERY OR CREMATORY<br>KING MEM. PARK  |   | 23d LOCATION<br>CITY OR TOWN COUNTY STATE<br>BALTIMORE CO., MD. |   |  |
| 24 FUNERAL DIRECTOR<br>NAME<br>Wm. C. MARCH F.H.  |  |   |  |  | ADDRESS<br>1101 E. NORTH AVE   |   | 25 DATE REC'D. BY REGISTRAR<br>DEC 31 1979                      |   | 25b REGISTRAR'S SIGNATURE<br><u>Robert A. Cheney</u> |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed within 72 hours after death. Page 3 may be retained by the hospital or attending physician.

TD FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  |   |  |   |  |   |  | 7 9 3 0 5 2 5<br>REG. NO.                    |  |
|--|--|--|--|---|--|---|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>CHARLES HENRY POWELL</b>   |  |  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>12 17 79</b> |   |  | 2b. HOUR<br><b>00.57</b> AM   |  |  |  |
| 3 SEX<br><b>MALE</b>   |  | 4 RACE<br><b>WHITE</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>06 02 18</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>62</b> YRS.   |  | 7. UNDER 1 YEAR<br>MONTHS DAYS  |  | 7. UNDER 24 HRS<br>HOURS MIN                 |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MARYLAND</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD                                |  |   |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>ST. AGNES HOSPITAL</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>NEVER WORKED</b>         |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |  |  |
| 13a. STATE<br><b>MARYLAND</b>  |  | 13b. COUNTY<br><b>BALTIMORE</b>  |  | 13c. CITY OR TOWN<br><b>ARBUTUS</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>1265 MAPLE AVENUE, 21227</b>  |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>GEORGE POWELL</b>   |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>CHARLOTTE UNKNOWN</b>   |  |   |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>  |  | 16b. SOCIAL SECURITY NO<br>(IF YES, GIVE WAR OR DATES)<br><b>218-03-2405</b>   |  | 17. INFORMANT<br>ADDRESS<br><b>HELEN KRAMMER, 1265 MAPLE AVENUE, 21227</b>  |  |   |  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Ruptured Dissecting thoracic aortic aneurysm</b><br>4410<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |  |  |  |   |  |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)  |  |  |  |   |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |  |   |  |   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.  |  |  |  |   |  |   |  |   |  |  |  |
| 22b. SIGNATURE<br><i>Anthony A. ARZ</i>  |  |  |  | DEGREE<br><b>MD</b>   |  |   |  | 22c. DATE SIGNED<br><b>12/17/79</b>   |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Anthony A. ARZ, MD</b>   |  |  |  | 22e. ADDRESS<br><b>900 CATON AVE. BALTIMORE, MD. 21229</b>  |  |   |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>CREMATION</b>  |  | 23b. DATE<br><b>12-18-79</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>LOUDON PARK</b>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>BALTIMORE CITY MARYLAND</b>                    |  |   |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>HUBBARD FUNERAL HOME, INC.</b>  |  | ADDRESS<br><b>4107 WILKENS AVE.</b>  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>DEC 19 1979</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><i>Anthony A. ARZ</i>   |  |   |  |  |  |

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BALTIMORE CITY

BALTIMORE ST. AGNES HOSPITAL

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| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  |   |   |  |   |  |  |  |
|--|--|---|--|---|---|--|---|--|--|--|
| 1 - FOR STATE REGISTRAR  |  |   | 7 9 3 0 5 2 6<br>REG. NO.  |   |   |  |   |  |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>EVERETT JACKSON POWELL</b>   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>DECEMBER, 13, 1979</b>       |   |   |  | 2b. HOUR<br><b>2:30P. M</b>   |  |  |  |
| 3 SEX<br><b>MALE</b>   |  | 4 RACE<br><b>WHITE</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>JULY 10, 1904</b>  |   | 6 AGE (IN YEARS LAST BIRTHDAY)<br><b>75</b> YRS.   |   | 7. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.   |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>SALISBURY, MD.</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. <b>BALTIMORE CITY OR COUNTY OF DEATH</b><br><b>BALTIMORE CITY, MD.</b>  |   |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE, MD.</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>433 HORNEL ST. # 21224,</b> |  |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>RETIRED</b>   |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>HARBOR TOWING CO.</b>  |  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>MD.</b>   |  |   | 13b. COUNTY<br><b>BALTIMORE</b>  |   | 13c. CITY OR TOWN<br><b>BALTIMORE</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>433 HORNEL ST. #21224.</b> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>JOHN W. POWELL</b>  |  |   |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>EVA KELLY</b>                     |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>  |  |   | 16b. SOCIAL SECURITY NO.<br><b>224-14-8303A</b>                        |   | 17. INFORMANT<br>ADDRESS<br><b>433 HORNEL ST. HOMER W. POWELL, BALTO., 21224, MD.</b> |  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiac arrest</b><br><b>4149</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DO TO, OR AS A CONSEQUENCE OF<br>(b) <b>Ischemic heart disease</b><br>DO TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |   |  |   |   |  |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)<br><b>Mitral regurgitation - recent onset</b>  |  |   |  |   |   |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>      |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)        |  |   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                     |  |   |  |  |  |
| 22a. I certify that (I) <del>examined</del> attended the deceased from <b>December 1977</b> , to <b>December 13, 1979</b> , that (I) <del>(we)</del> last saw the deceased alive on <b>November 30, 1979</b> , and that in (my) <del>(our)</del> opinion death occurred on the date and hour and from the causes stated above, (I) <del>(we)</del> <del>(did)</del> <del>(did not)</del> view the body after death.                        |  |   |  |   |   |  |   |  |  |  |
| 22b. SIGNATURE<br><b>JAMES KEOGH MD</b>  |  |   |  |   |   | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |   | 22c. DATE SIGNED<br><b>12/14/79</b>  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>JAMES KEOGH</b>  |  |   |  |   | 22e. ADDRESS<br><b>6216 EASTERN AVE., BALTO., 21224, MD.</b>                          |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>BURIAL</b>   |  |   | 23b. DATE<br><b>12-16-79</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>PARKSLEY CEMETERY</b>                        |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>PARKSLEY ACCOMAC CO., VA.</b>                  |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Charles S. Seiler &amp; Son, Inc., BALTO., 21224, MD.</b>   |  |   |  |   | 25a. DATE REC'D. BY REGISTRAR<br><b>DEC 17 1979</b>                                   |  | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>  |  |  |  |



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JULY 10, 1968

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1968

WILLIAMS, J.

WILLIAMS, J.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

7930527

REG. NO.

|   |  |  |  |   |  |  |  |   |  |
|---|--|--|--|---|--|--|--|---|--|
| 1. FOR<br>STATE<br>REGISTRAR  |  | 1. DECEASED NAME<br>(TYPE OR PRINT)  |  | FIRST MIDDLE LAST<br>MAURICE S. POZANEK   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>12 9 79   |  | 2b. HOUR<br>2:15 AM   |  |
| 3. SEX<br>MALE  |  | 4. RACE<br>WHITE   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>8 18 02   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>77 YRS  |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.                |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN)<br>MARYLAND  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD.   |  |   |  |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>SINAI HOSPITAL OF BALTIMORE, INC. |  | 12a. USUAL OCCUPATION<br>(TYPE OR WORKING LIFE)<br>SALESMAN   |  | 12b. KIND OF BUSINESS OR<br>RETAIL   |  |   |  |
| 13a. STATE<br>MARYLAND  |  | 13b. COUNTY<br>BALTIMORE   |  | 13c. CITY OR TOWN<br>BALTIMORE  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |  | 13e. STREET ADDRESS<br>GLENGLYLE #21215<br>4006 GLENGLYLE AVE.                    |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>LOUIS POZANEK   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>BELLE SAMUELS   |  |   |  |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>NO  |  | 16b. SOCIAL SECURITY NO.<br>220-05-9856  |  | 17. INFORMANT<br>MRS. JEAN POZANEK  |  | 4006 GLENGLYLE AVE., APT. D #21215   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Respiratory Arrest</u><br>2028 DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>SEPSIS - E. coli, Clostridia</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>SMALL BOWEL OBSTRUCTION, LYMPHOMA</u> |  |  |  |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>coincident<br>2 weeks<br>2 months |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):<br><u>MALNUTRITION</u>   |  |  |  |   |  |  |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>11-28</u> 19 <u>79</u> to <u>12-10</u> 19 <u>79</u> , that (I) (we) lost saw the deceased alive on <u>12-10-79</u> 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |  |  |   |  |  |  |   |  |
| 22b. SIGNATURE<br><u>Michael McIvor</u>   |  | DEGREE<br>MD   |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>       |  | 22c. DATE SIGNED<br>12-10-79   |  |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>MICHAEL McIVOR   |  | 22e. ADDRESS<br>SINAI HOSPITAL OF BALTIMORE, INC.  |  |   |  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>BURIAL  |  | 23b. DATE<br>DEC. 11, 1979   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>BALTIMORE HEBREW  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>REISTERSTOWN BALTO. MD   |  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME SOL LEVINSON & BROS., INC.<br>6010 REISTERSTOWN RD. BALTO., MD 21215   |  | 25a. DATE REC'D. BY REGISTRAR<br>DEC 13 1979   |  | 25b. REGISTRAR'S SIGNATURE<br><u>Robert McCreedy</u>  |  |  |  |   |  |

MEDICAL CERTIFICATION

99

1


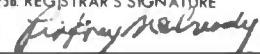
2720 BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

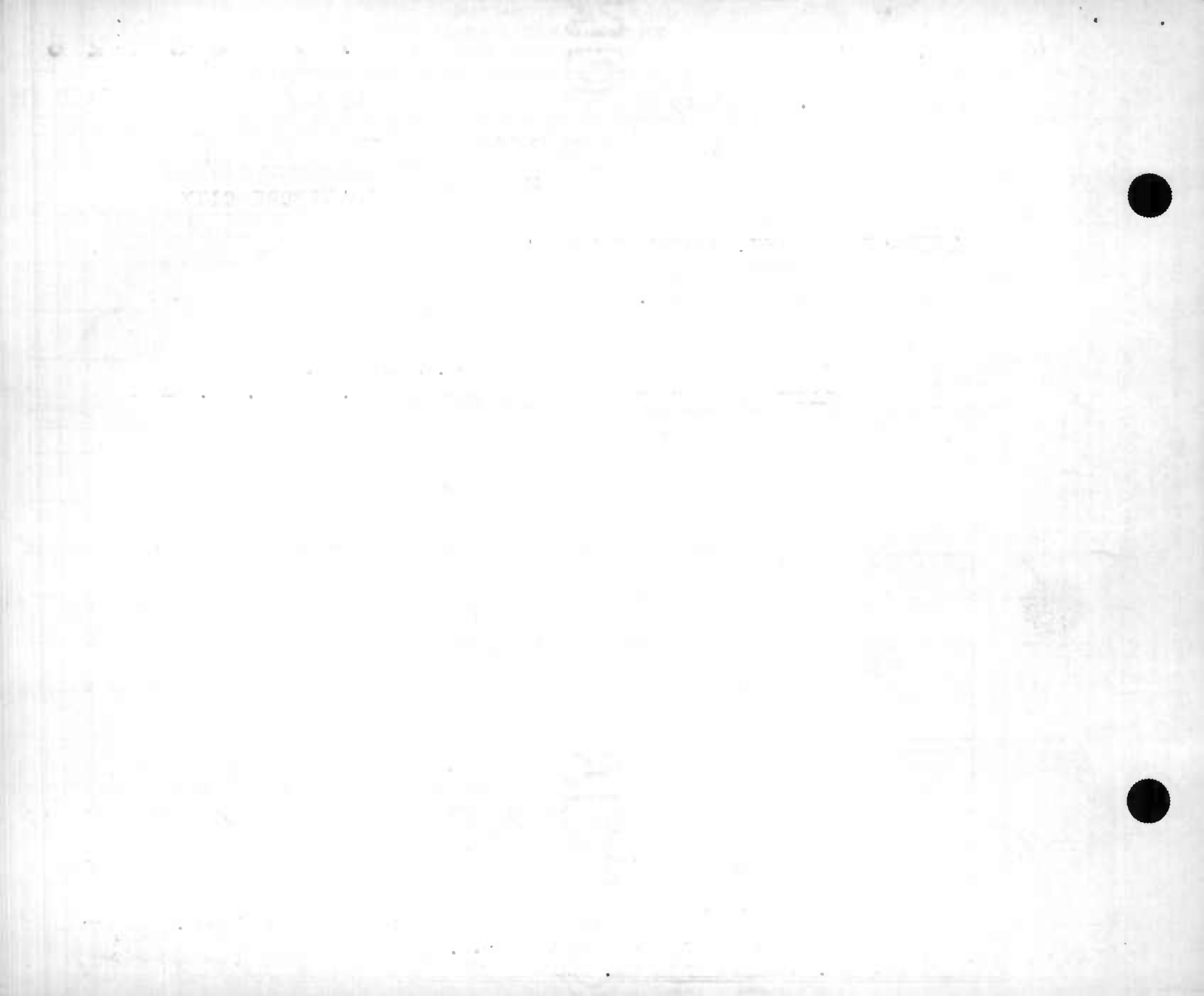
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  |   |  |   |  |  |  |
|--|--|---|--|---|--|---|--|--|--|
| 1. FOR STATE REGISTRAR   |  | 7 9 3 0 5 2 8<br>REG. NO.   |  | 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Josephine M. Prezioso  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>12/12/79   |  | 2b. HOUR<br>2:50 PM  |  |
| 3 SEX<br>Female  |  | 4 RACE<br>white   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>11/15/04  |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br>75<br>YRS.  |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD.  |  |  |  |
| 10 CITY OR TOWN OF DEATH<br>BALTIMORE  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>ST. AGNES HOSPITAL |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Housewife                                       |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  |   |  |   |  |   |  |  |  |
| 13a. STATE<br>Maryland   |  | 13b. COUNTY<br>Baltimore  |  | 13c. CITY OR TOWN<br>Balto. County  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                     |  | 13e. STREET ADDRESS<br>2659 West Park Drive  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Ignatius Libertini   |  |   |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Rosalie Tornabene |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>NO   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>220-05-2500B   |  | 17. INFORMANT<br>Mr. Anthony D. Prezioso<br>2659 West Park Dr. Balto. MD. 21207   |  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>uterine Sarcoma</u><br>179-<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Uremia.</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |   |  |   |  |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |   |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)  |  |   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |   |  |   |  |   |  |  |  |
| 22b. SIGNATURE<br>  |  | DEGREE<br>M.D.  |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>       |  | 22c. DATE SIGNED<br>Dec. 12. '79  |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>OK SUK KIM  |  |   |  | 22e. ADDRESS<br>ST. AGNES HOSPITAL.   |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial   |  | 23b. DATE<br>12/15/79   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Lorraine Park Cemetery  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Woodlawn Balto. Md.   |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Loring Byers Funeral Directors, P.A.<br>8728 Liberty Rd. Randallstown, MD. 21133   |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br>DEC 13 1979  |  | 25b. REGISTRAR'S SIGNATURE<br> |  |  |  |

BP \_\_\_\_\_

DHMM-16 20M  
(VRA 15, 4) 7/78



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

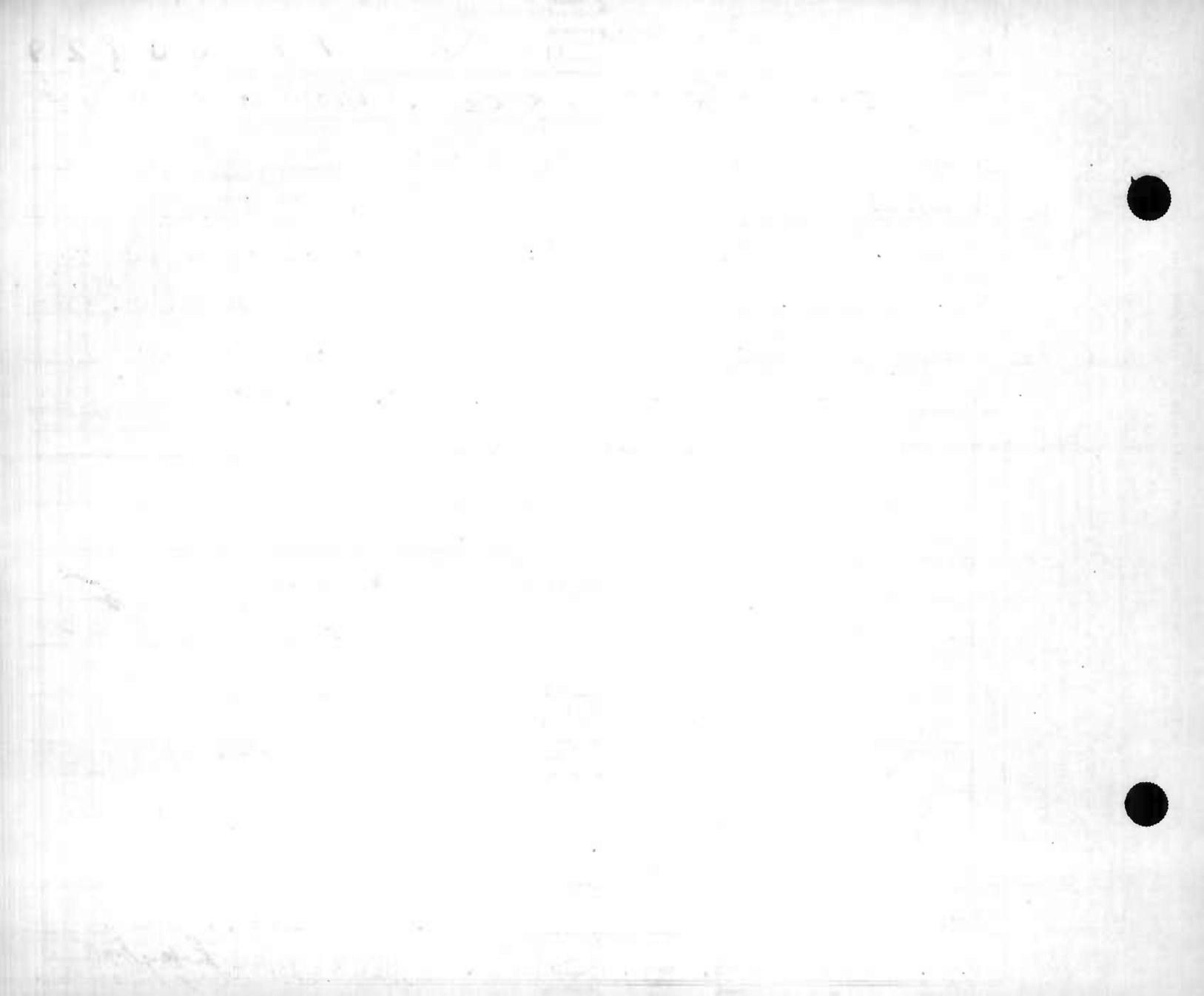
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  |   |  |   |  |   |       |
|--|--|---|--|---|--|---|--|---|-------|
| 1. FOR STATE REGISTRAR   |  | 7 9   |  | 3 0 5 2 9   |  | REG. NO.  |  |   |       |
| 1. DECEASED NAME (TYPE OR PRINT)   |  | FIRST MIDDLE LAST<br>JAMES McDonnell PRICE Jr.  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br>12/27/79 Dec. 27 <sup>th</sup> , 1979   |  | 2b. HOUR<br>9 <sup>50</sup> P <sup>M</sup>  |  |   |       |
| 3 SEX<br>Male  |  | 4 RACE<br>White   |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>10 18 1903   |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br>76 YRS.   |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.                   |       |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD.  |  |   |       |
| 10 CITY OR TOWN OF DEATH<br>BALTIMORE  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>UNION MEMORIAL HOSPITAL |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Operations Mgr   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Oil Industry   |  |   |       |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>Md.  |  | 13b. COUNTY<br>Balto.   |  | 13c. CITY OR TOWN<br>Timonium   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                       |  | 13e. STREET ADDRESS<br>2118 Fountain Hill Dr. Timonium, Md. |       |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>James McDonnell Price   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Amelia H. Shryock   |  |   |  |   |  |   |       |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>No  |  | 16b. SOCIAL SECURITY NO.<br>225-05-2452   |  | 17. INFORMANT ADDRESS<br>Mrs. May A. Price, 2118 Fountain Hill Dr.  |  |   |  |   |       |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cardiac arrest</u><br>1533<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Myocardial Infarction.</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |   |  |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                |       |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):<br><u>COPD s/p sigmoid resection for Carcinoma.</u>   |  |   |  |   |  |   |  |   |       |
| 19a. DATE OF OPERATION<br>12/21/79   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br>Carcinoma of sigmoid colon  |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |   |       |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |   |       |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION STREET  |  | CITY OR TOWN  |  | COUNTY  | STATE |
| 22. I certify that (I) (his hospital) attended the deceased from <u>12/21/1979</u> to <u>12/27/1979</u> , that (I) (we) lost saw the deceased give on <u>12/27/1979</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.   |  |   |  |   |  |   |  |   |       |
| 22b. SIGNATURE<br>Onkar Nath Singh   |  | DEGREE<br>MD  |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>                  |  | 22c. DATE SIGNED<br>12/27/79  |  |   |       |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>ONKAR NATH SINGH  |  | 22e. ADDRESS<br>UNION MEMORIAL HOSPITAL   |  |   |  |   |  |   |       |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial  |  | 23b. DATE<br>12/29/79   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Druid Ridge Cem.  |  | 23d. LOCATION CITY OR TOWN<br>Baltimore, Maryland   |  | COUNTY  | STATE |
| 24. FUNERAL DIRECTOR NAME<br>J. E. Lowell Lemmon   |  |   |  | ADDRESS<br>10 W. Padonia Rd.  |  | 25a. DATE REC'D. BY REGISTRAR<br>DEC 31 1979  |  | 25b. REGISTRAR'S SIGNATURE<br>[Signature]                   |       |

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DHMH-16 20M  
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

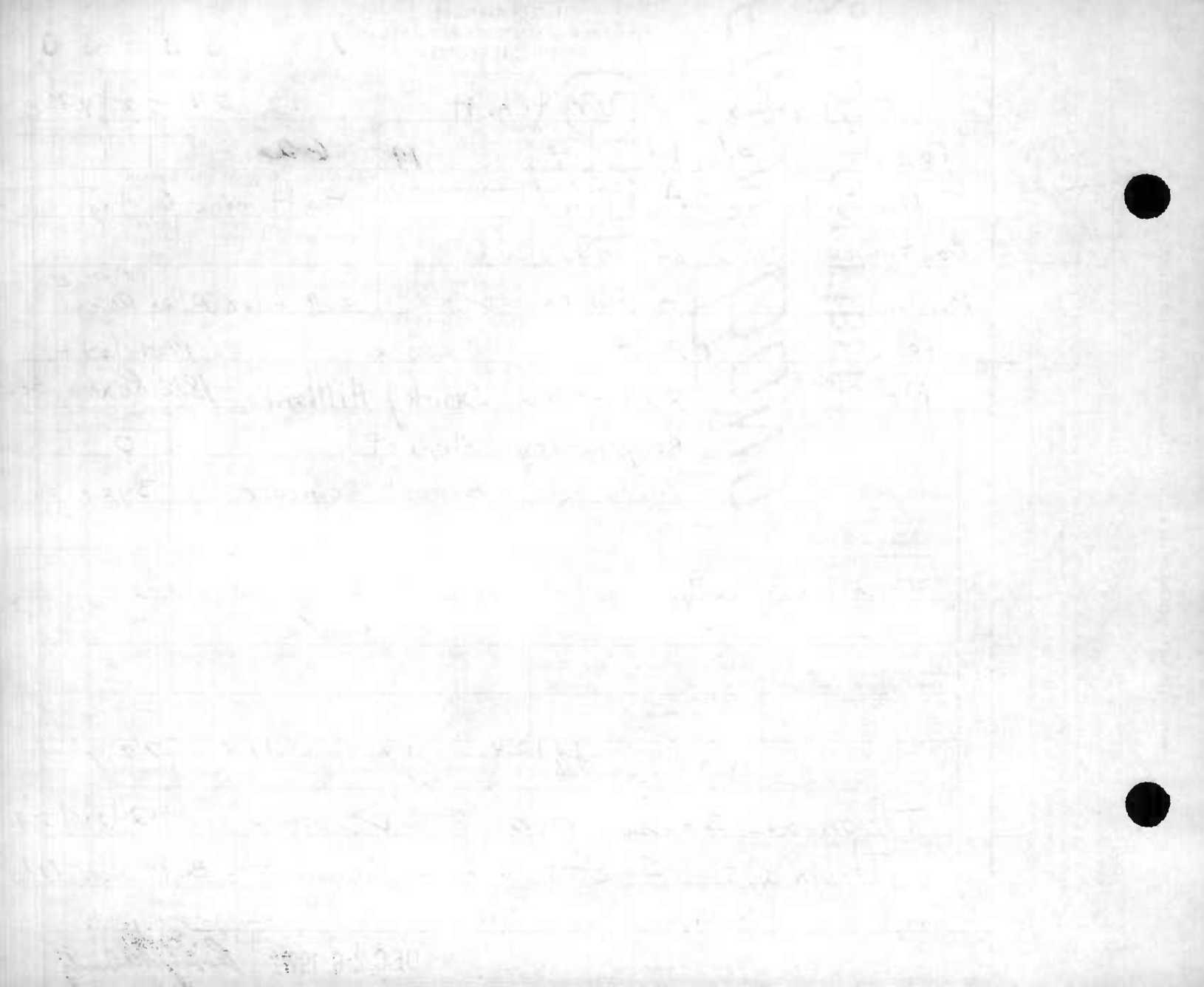
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

7 9 3 0 5 3 0  
REG. NO.

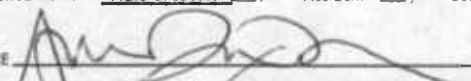
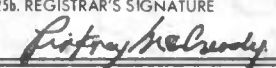
|   |  |   |  |  |                                       |  |
|---|--|---|--|--|---------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><i>Captoria Pritchett</i>   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><i>12 24 79</i>                   |  | 2b. HOUR<br><i>9:20 AM</i>            |  |
| 3 SEX<br><i>Female</i>  |  | 4 RACE<br><i>Black</i>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><i>4 10 17</i>                                 |                                       |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><i>Maryland</i>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><i>USA</i>  |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br>YRS. MONTHS DAYS<br><i>62</i>                      |                                       |  |
| 10 CITY OR TOWN OF DEATH<br><i>Baltimore</i>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><i>Univ. of Maryland</i> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><i>Baltimore City</i> MD.                     |                                       |  |
| 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)  |  |   | 12b. KIND OF BUSINESS OR INDUSTRY  |  |                                       |  |
| 13a. STATE<br><i>Maryland</i>   |  |   | 13b. COUNTY<br><i>Baltimore</i>  |  | 13c. CITY OR TOWN<br><i>Baltimore</i> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><i>Felix Pritchett</i>  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><i>Cassie Pritchett</i> |  |                                       |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><i>No</i>   |  | 16b. SOCIAL SECURITY NO.<br><i>228-24-8932</i>  |  | 17 INFORMANT<br>ADDRESS<br><i>Shirley Hilliard 1812 Ruxton St.</i>                   |                                       |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Respiratory Arrest.</i><br><i>1749</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <i>Metastatic Breast Cancer</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><i>0</i><br><i>3 years.</i> |  |   |  |  |                                       |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):<br><i>Thrombosis of axillary artery and 2° arm gangrene</i>  |  |   |  |  |                                       |  |
| 19a. DATE OF OPERATION<br>—   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br>—   |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                       |  |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  |   |  |  |                                       |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)       |                                       |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |                                       |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>12/24 1979</i> , to <i>12/24 1979</i> , that (I) (we) lost saw the deceased alive on <i>12/24 1979</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |   |  |  |                                       |  |
| 22b. SIGNATURE<br><i>Thomas Sachs M.D.</i>  |  |   |  | 22c. DATE SIGNED<br><i>12/24/79</i>  |                                       |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><i>Thomas Sachs</i>  |  |   |  | 22e. ADDRESS<br><i>22 S. Green St. Baltimore Md</i>                                  |                                       |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><i>Burial</i>  |  | 23b. DATE<br><i>12/28/79</i>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><i>Cedar Hill Cem.</i>                         |                                       |  |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><i>Anne Arundel Co., Md.</i>  |  |   |  |  |                                       |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><i>Wm C March F/H 1101 E. North Ave.</i>  |  | 25a. DATE REC'D. BY REGISTRAR<br><i>DEC 26 1979</i>   |  | 25b. REGISTRAR'S SIGNATURE<br><i>Richard M. [Signature]</i>                          |                                       |  |





TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH   |  |                              |  |  |  |   |  |   |  | REG. NO. 30531  |  |                                |  |
|---|--|------------------------------|--|--|--|---|--|---|--|---|--|--------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) FIRST MIDDLE LAST<br><b>LILLIAN M. PRITCHETT</b>  |  |                              |  |  |  |   |  |   |  | 2a. DATE KNOWN OF DEATH<br>ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR<br><b>12 22 19 79</b> |  | 2b. HOUR<br>M<br><b>5:45 P</b> |  |
| 3. SEX<br><b>female</b>   |  | 4. RACE<br><b>white</b>      |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>6-13-1903</b>   |  | 6. AGE (IN YEARS)<br>LAST BIRTHDAY<br><b>76 YRS.</b>  |  | IF UNDER 1 YR.<br>MONTHS DAYS HOURS MIN.  |  | 2c. DATE PRONOUNCED DEAD<br>MONTH DAY YEAR<br><b>12 22 19 79</b>  |  |                                |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MARYLAND.</b>   |  |                              |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  |   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.   |  |                                |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   |  |                              |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>624 N. Castle St.</b> |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>CLERK</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>CHRISTIAN BOOK STORE</b>  |  |                                |  |
| 13a. STATE<br><b>MD</b>   |  |                              |  | 13b. CITY OR TOWN<br><b>BALTO.</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>624 N. CASTLE ST.</b>   |  |   |  |                                |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>GRUENINGER</b>   |  |                              |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>CARRIE LEWIS</b>                            |  |   |  |   |  |                                |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br><b>No</b>  |  |                              |  | 16b. SOCIAL SECURITY NO.<br><b>218-36-7621</b>   |  | 17. INFORMANT ADDRESS<br><b>John W. Pritchett - 859 Glen Wood Bld.</b>                          |  |   |  |   |  |                                |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>4280 Congestive heart failure</b><br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>DUE TO, OR AS A CONSEQUENCE OF   |  |                              |  |  |  |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |                                |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).   |  |                              |  |  |  |   |  |   |  |   |  |                                |  |
| 19a. DATE OF OPERATION  |  |                              |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |  |   |  |   |  | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                           |  |                                |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |  |                              |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)                   |  |   |  |   |  |                                |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |                              |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |   |  |                                |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . |  |                              |  |  |  |   |  |   |  |   |  |                                |  |
| ACTUAL SIGNATURE<br>   |  |                              |  | TITLE (SPECIFY)<br>M.D. <b>Assistant</b> MEDICAL EXAMINER  |  |   |  | DATE SIGNED <b>12-24-79</b>   |  |   |  |                                |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT)<br><b>Ann M. Dixon, M.D.</b>   |  |                              |  | ADDRESS<br><b>111 Penn St.</b>   |  |   |  |   |  |   |  |                                |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>BURIAL</b>   |  | 23b. DATE<br><b>12-29-79</b> |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>MORELAND CEMETERY</b>   |  |   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>BALTO. MD.</b>   |  |   |  |                                |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Garth Miller</b> ADDRESS<br><b>2334 Chippewa St.</b>   |  |                              |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>DEC 26 1979</b>   |  | 25b. REGISTRAR'S SIGNATURE<br>   |  |   |  |                                |  |



STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

7 9 3 0 5 3 2

REG. NO.

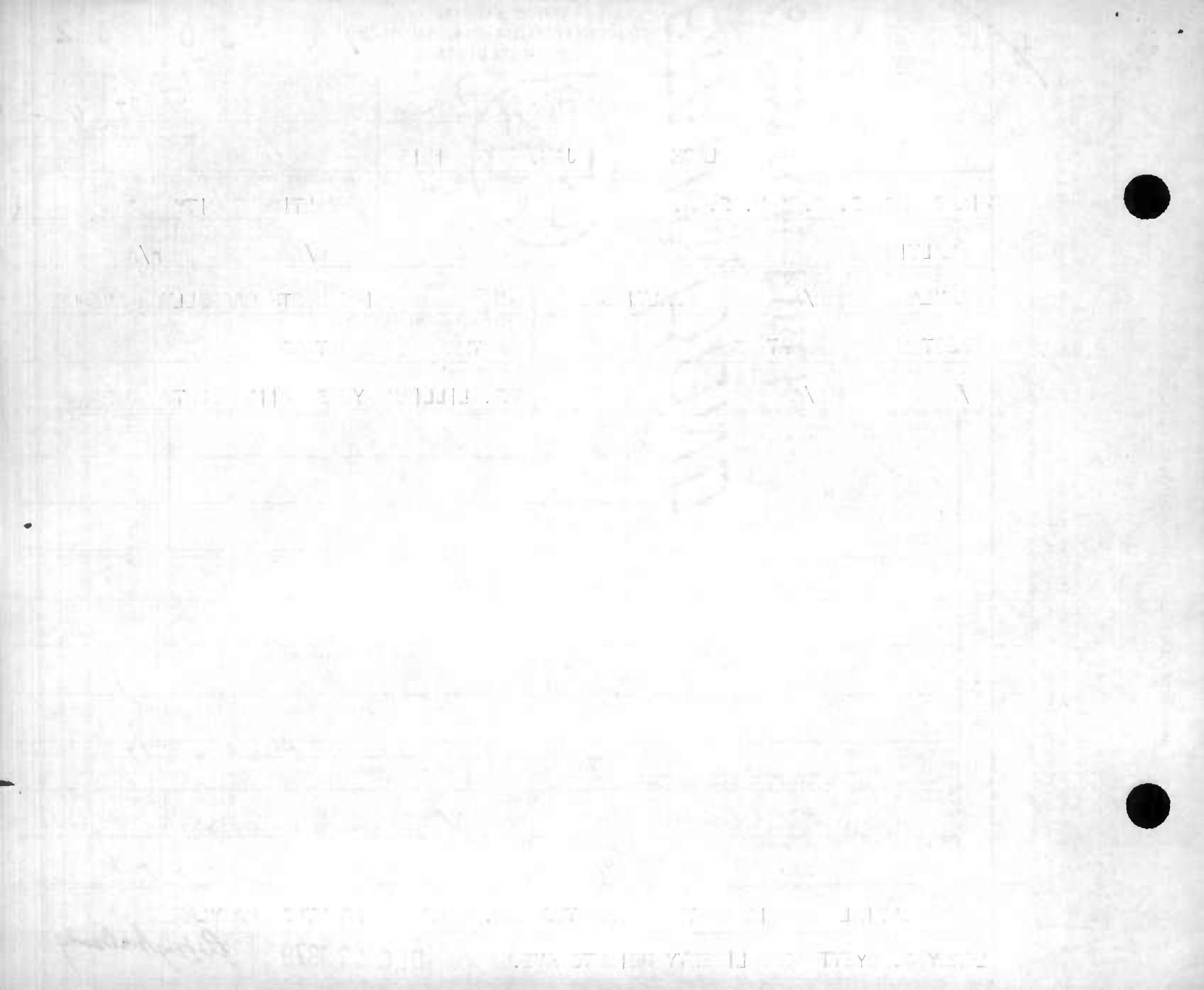
1- FOR  
STATE  
REGISTRAR

|   |  |   |   |   |   |   |  |  |  |
|---|--|---|---|---|---|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>LOIS PROCTOR</b>   |  |   | 2a. DATE OF DEATH<br>MONTH <b>12</b> DAY <b>21</b> YEAR <b>79</b> |   |   | 2b. HOUR<br><b>6:45</b> AM  |  |  |  |
| 3. SEX<br><b>F</b>  |  | 4. RACE<br><b>BLACK</b>   |   | 5. DATE OF BIRTH<br>MONTH <b>JAN.</b> DAY <b>6</b> YEAR <b>1915</b>   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>64</b> YRS  |  | IF UNDER 1 YEAR<br>MONTHS<br>DAYS<br>IF UNDER 24 HRS<br>HOURS<br>MIN   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>WINNSBORO, S. C.</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U. S. A.</b>   |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.                               |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT KNOWN, GIVE STREET ADDRESS)<br><b>Lutheran</b> |   |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>N/A</b>                  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>N/A</b>  |  |
| 13a. RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  |   |   |   |   |   |  |  |  |
| 13a. STATE<br><b>MARYLAND</b>   |  | 13b. COUNTY<br><b>N/A</b>   |   | 13c. CITY OR TOWN<br><b>BALTIMORE</b>   |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>105 NORTH CARROLLTON AVENUE</b>  |  |
| 14. FATHER'S NAME<br>FIRST <b>PRESTON</b> MIDDLE <b>WATERS</b> LAST   |  |   |   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>MARTHA</b> MIDDLE <b>WATERS</b> LAST |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>N/A</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>N/A</b>  |   | 17. INFORMANT ADDRESS<br><b>MRS. LILLIAN MYERS 4112 MOUNTWOOD ROAD</b>  |   |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Acute myocardial infarction</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>410-</b><br>Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost.<br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>congestion heart failure</b> |  |   |   |   |   |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>1 wk</b>  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |   |   |   |   |   |  |  |  |
| 19a. DATE OF OPERATION<br><b>-</b>  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>-</b>  |   |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                       |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. <b>19</b>   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |   |   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>Dec 7</b> , 19 <b>79</b> , to <b>Dec 21</b> , 19 <b>79</b> , that (I) (we) lost<br>saw the deceased alive on <b>Dec 21</b> , 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.                 |  |   |   |   |   |   |  |  |  |
| 22b. SIGNATURE<br><b>Araya Chansanchai</b> MD   |  |   |   |   |   | DEGREE<br><b>MD</b>   |  | 22c. DATE SIGNED<br><b>12/21/79</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>ARAYA CHANSANCHAI</b>   |  |   |   |   |   | 22e. ADDRESS<br><b>Lutheran Hospital</b>  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY) <b>BURIAL</b>  |  | 23b. DATE<br><b>12-28-79</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>ARBUTUS MEM. PARK</b>  |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>ARBUTUS, MARYLAND</b>                          |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME <b>LEROEY O. DYETT</b> ADDRESS <b>4600 LIBERTY HEIGHTS AVE.</b>  |  |   |   |   |   | 25a. DATE REC'D. BY REGISTRAR<br><b>DEC 27 1979</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>L. H. H. H.</b>   |  |

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PA 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH   |  |                         |  |   |  |  |  |   |  | REG. NO. 30533  |  |
|---|--|-------------------------|--|---|--|--|--|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>A. THEODORE (THEDFORD) PURCELL</b>   |  |                         |  |   |  |  |  |   |  | 2a. DATE KNOWN OF DEATH<br>ESTIMATED <input checked="" type="checkbox"/> MONTH <b>12</b> DAY <b>26</b> YEAR <b>1979</b> |  |
| 3. SEX<br><b>male</b>   |  | 4. RACE<br><b>black</b> |  | 5. DATE OF BIRTH<br>MONTH <b>9</b> DAY <b>19</b> YEAR <b>14</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>65</b> YRS.          |  | IF UNDER 1 YR. MONTHS DAYS  |  | IF UNDER 24 HRS. HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>N.C.</b>  |  |                         |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  |  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b>   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   |  |                         |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(OR IN WHICH FACILITY, GIVE STREET ADDRESS)<br><b>1216 Bonaparte Avenue</b> |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)   |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  |                         |  |   |  |  |  |   |  |   |  |
| 13a. STATE<br><b>Maryland</b>   |  |                         |  | 13b. COUNTY   |  | 13c. CITY OR TOWN<br><b>Baltimore</b>                      |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 13e. STREET ADDRESS<br><b>1216 Bonaparte Ave.</b>   |  |
| 14. FATHER'S NAME<br>FIRST <b>MOSES</b> MIDDLE LAST <b>PURCELL</b>  |  |                         |  | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>LIZZIE</b> MIDDLE LAST   |  |  |  |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>No</b>  |  |                         |  | 16b. SOCIAL SECURITY NO.<br><b>238-28-4097</b>  |  | 17. INFORMANT<br><b>DORIS PURCELL</b>                      |  | ADDRESS<br><b>1003 Halstead Rd.</b>   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1 DEATH WAS CAUSED BY: <b>Arteriosclerotic cardiovascular disease</b>   |  |                         |  |   |  |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |
| IMMEDIATE CAUSE (a) <b>4292</b><br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last:<br>DUE TO, OR AS A CONSEQUENCE OF  |  |                         |  |   |  |  |  |   |  |   |  |
| (b)<br>DUE TO, OR AS A CONSEQUENCE OF   |  |                         |  |   |  |  |  |   |  |   |  |
| (c)<br>DUE TO, OR AS A CONSEQUENCE OF   |  |                         |  |   |  |  |  |   |  |   |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):   |  |                         |  |   |  |  |  |   |  |   |  |
| 19a. DATE OF OPERATION  |  |                         |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |  |  |  | HEAD ONLY<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  |   |  |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |  |                         |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. <b>19</b>   |  |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  |                         |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)   |  |  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |
| 22a. I certify that I took charge of the remains described above, held on autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: <b>Natural causes</b> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |  |                         |  |   |  |  |  |   |  |   |  |
| ACTUAL SIGNATURE<br><i>Margarita A. Korell</i>  |  |                         |  | TITLE (SPECIFY)<br><b>Assistant</b>   |  |  |  | DATE SIGNED<br><b>12/27/79</b>  |  |   |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT)<br><b>Margarita A. Korell, M.D.</b>  |  |                         |  | ADDRESS<br><b>111 Penn Street</b>   |  |  |  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   |  |                         |  | 23b. DATE<br><b>12-31-79</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>KING MEM. PK.</b> |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>BALTIMORE CO. MD.</b>  |  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Wm. C. March F/H</b>   |  |                         |  | ADDRESS<br><b>1101 E. North Ave.</b>  |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>DEC 28 1979</b>   |  | 25b. SIGNATURE<br><i>[Signature]</i>  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

RELEASED ON APPROVAL BY DR. DIXON OF THE MEDICAL TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and properly filed, it may be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene.

EXAMINER'S OFFICE

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |                  |  |  |  |  |   |  |  | REG. NO. 79 30534                                    |  |
|---|--|------------------|--|--|--|--|---|--|--|--|--|
| 1. FOR STATE REGISTRAR  |  |                  | 2a. DECEASED NAME<br>(TYPE OR PRINT) <b>ELOIS Purviance</b>  |  |  |  | 2b. DATE OF DEATH<br>MONTH DAY YEAR <b>12 28 79</b>   |  |  | 2c. HOUR <b>1145 A.M.</b>                            |  |
| 3. SEX <b>F</b>   |  | 4. RACE <b>B</b> |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR <b>07 16 31</b> |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>48</b> YRS.  |   | 7. IF UNDER 1 YEAR<br>MONTHS DAYS                                      |  | 7. IF UNDER 24 HRS<br>HOURS MIN.                     |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>  |  |                  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>    |   |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   |  |                  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>JOHNS HOPKINS HOSPITAL</b> |  |  |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)                                |  |  | 12b. KIND OF BUSINESS OR INDUSTRY                    |  |
| 13a. STATE<br><b>Maryland</b>   |  |                  | 13b. COUNTY  |  | 13c. CITY OR TOWN<br><b>Baltimore</b>                          |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>2823 E. Biddle St.</b>   |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>BRADFORD</b>   |  |                  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>ANNIE MAE WILLIAMS</b>   |  |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>  |   |  | 16b. SOCIAL SECURITY NO.<br><b>217-24-3461</b>   |  |  |
| 17. INFORMANT<br>ADDRESS<br><b>Hampton, Va.</b>   |  |                  | 18. CRAIG PURVIANCE  |  |  | 19. 14 Renden Dr.  |   |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1 DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>IntraCerebral bleeding</b>  |  |                  |  |  |  |  |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH         |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>Hypertension</b>   |  |                  |  |  |  |  |   |  |  |  |  |
| (c)   |  |                  |  |  |  |  |   |  |  |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).   |  |                  |  |  |  |  |   |  |  |  |  |
| 19a. DATE OF OPERATION<br><b>12/27/79</b>   |  |                  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>Relief IntraCranial Pressure</b>  |  |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |                  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. <b>19</b>  |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |   |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  |                  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |   |  |  |  |  |
| 22. I certify that (he) (this hospital) attended the deceased from <b>12/27</b> 19 <b>79</b> to <b>12/28</b> 19 <b>79</b> , that (he) (we) lost saw the deceased alive on <b>12/28</b> 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (he) (we) (did) (did not) view the body after death. |  |                  |  |  |  |  |   |  |  |  |  |
| 22b. SIGNATURE<br><b>A. S. Farrukh</b>  |  |                  |  |  |  | DEGREE <b>MD</b><br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |   |  | 22c. DATE SIGNED<br><b>12/28/79</b>  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>A. S. Farrukh</b>   |  |                  |  |  |  | 22e. ADDRESS<br><b>601 NORTH BROADWAY</b>  |   |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Cremation</b>  |  |                  | 23b. DATE<br><b>12-29-79</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>WESTVIEW MEM. PK.</b> |  |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>BALTIMORE CO. MD.</b> |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Wm. C. March F/H</b>   |  |                  |  |  |  | ADDRESS<br><b>1101 E. North Ave.</b>   |   | 25a. DATE REC'D. BY REGISTRAR<br><b>DEC 31 1979</b>                    |  | 25b. REGISTRAR'S SIGNATURE<br><b>Robert McCreedy</b> |  |



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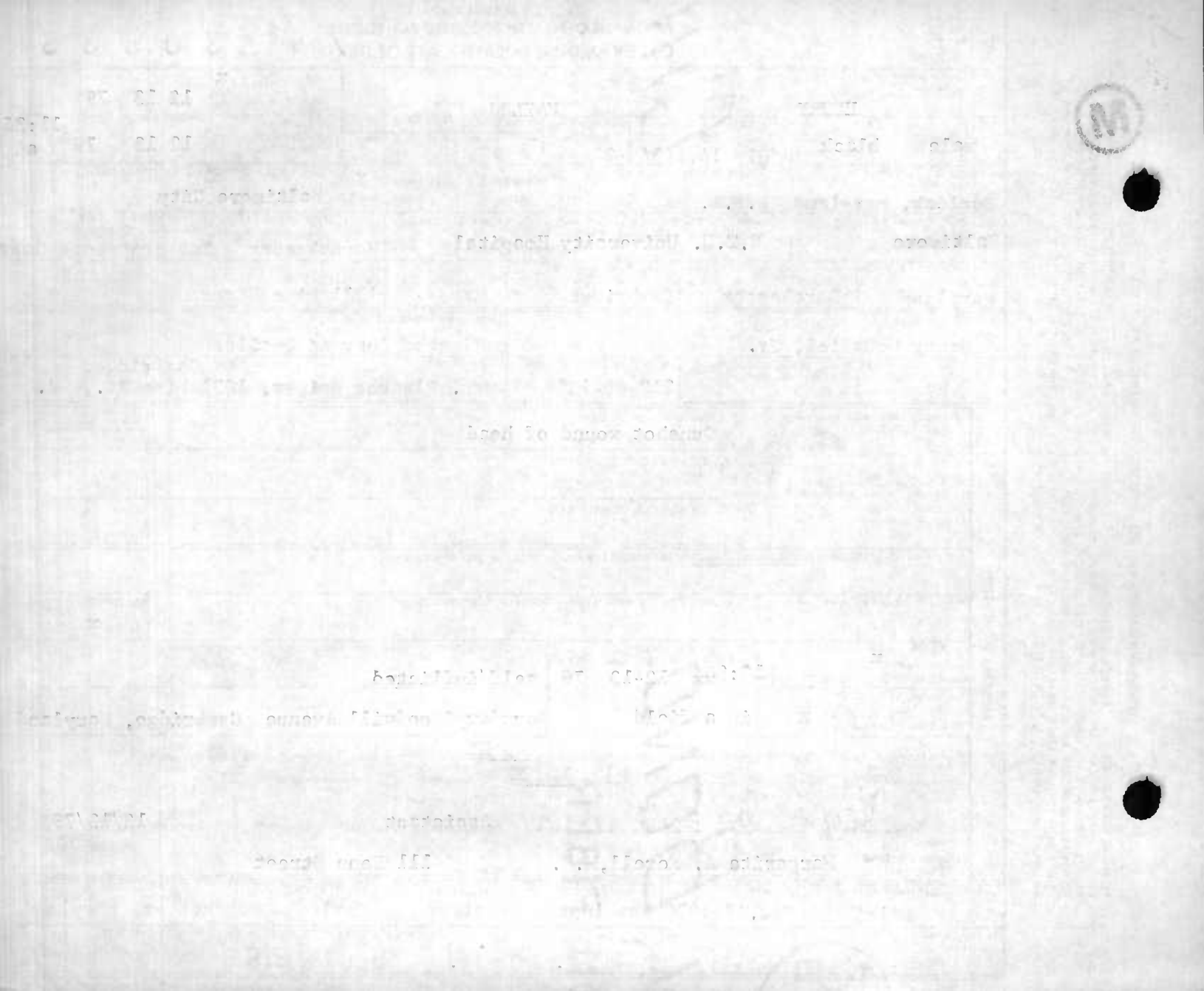


**STATE OF MARYLAND**  
**DEPARTMENT OF HEALTH AND MENTAL HYGIENE**  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

REG. NO. **3 0 5 3 5**

|  |   |   |   |   |   |   |  |
|--|---|---|---|---|---|---|--|
| 1- FOR STATE REGISTRAR   |   | 2a. DATE KNOWN OF DEATH                                     |   | MONTH DAY YEAR  |   | 2b. HOUR  |  |
| 1. DECEASED NAME (TYPE OR PRINT)   |   | FIRST MIDDLE LAST   |   | MONTH DAY YEAR  |   | MONTH DAY YEAR  |  |
| HENRY LEE QUATLES  |   |   |   | 12 13 79  |   | 11:35 a.m.  |  |
| 3 SEX  | 4 RACE  | 5. DATE OF BIRTH  | 6 AGE (IN YEARS LAST BIRTHDAY)  | IF UNDER 1 YR.  | IF UNDER 24 HRS.                        | 7c. DATE PRONOUNCED DEAD  |  |
| male   | black   | July 14, 1954   | 25 YRS.   |   |   | 12 13 79  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  | 7b. CITIZEN OF WHAT COUNTRY?  |   | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9 BALTIMORE CITY OR COUNTY OF DEATH     |   |  |
| Hurlock, Maryland  | U.S.A.  |   |   |   | Baltimore City MD.                      |   |  |
| 10. CITY OR TOWN OF DEATH  | NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF OTHER THAN SUCH FACILITY, GIVE STREET ADDRESS) |   |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                 |   | 12b. KIND OF BUSINESS OR INDUSTRY                                   |  |
| Baltimore  | S.I.U. University Hospital  |   |   | Housekeeper - Eastern Shore Hosp  |   |   |  |
| 13a. STATE   | 13b. COUNTY   | 13c. CITY OR TOWN   | 13d. INSIDE CITY LIMITS?  | 13e. STREET ADDRESS   |   |   |  |
| Maryland   | Dorchester  | Cambridge   | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   | 1031 Pine Street  |   |   |  |
| 14. FATHER'S NAME  |   |   | 15. MOTHER'S MAIDEN NAME  |   |   |   |  |
| FIRST MIDDLE LAST  |   |   | FIRST MIDDLE LAST   |   |   |   |  |
| Henry McDaniel, Jr.  |   |   | Blanche Annymae Quailles  |   |   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)   |   |   | 16b. SOCIAL SECURITY NO.  |   | 17. INFORMANT ADDRESS                   |   |  |
| No   |   |   | 212-66-1350   |   | Mrs. Blanche Spicer, 1031 Pine St., Md. |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |   |   |   |   |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART I DEATH WAS CAUSED BY:  |   |   |   |   |   |   |  |
| IMMEDIATE CAUSE (a)  |   |   |   |   |   |   |  |
| Gunshot wound of head  |   |   |   |   |   |   |  |
| DUE TO, OR AS A CONSEQUENCE OF   |   |   |   |   |   |   |  |
| (b)  |   |   |   |   |   |   |  |
| DUE TO, OR AS A CONSEQUENCE OF   |   |   |   |   |   |   |  |
| (c)  |   |   |   |   |   |   |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 a.  |   |   |   |   |   |   |  |
| 19a. DATE OF OPERATION   |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?           |   |   |   | 20. AUTOPSY?  |  |
|  |   |   |   |   |   | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |   | 21b. TIME OF INJURY   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) |   |   |  |
|  |   | 12:20 a.m. 12-13 79   |   | self/inflicted  |   |   |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>  |   | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) |   | 21f. LOCATION   |   |   |  |
|  |   | in a field  |   | Boundary & Goodwill Avenue Cambridge, Maryland                                |   |   |  |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |   |   |   |   |   |   |  |
| ACTUAL SIGNATURE   |   | TITLE (SPECIFY)   |   | DATE SIGNED   |   |   |  |
| Margarita A. Korell, M.D.  |   | Assistant   |   | 12/13/79  |   |   |  |
| EXAMINER'S NAME (TYPE OR PRINT)  |   | ADDRESS   |   |   |   |   |  |
| Margarita A. Korell, M.D.  |   | 111 Penn Street   |   |   |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |   | 23b. DATE   |   | 23c. NAME OF CEMETERY OR CREMATORY  |   | 23d. LOCATION   |  |
| Burial   |   | Dec. 17, 1979   |   | Washington Cemetery   |   | Hurlock, Dorchester, Maryland                                       |  |
| 24. FUNERAL DIRECTOR NAME  |   | ADDRESS   |   | 25a. DATE REC'D. BY REGISTRAR   |   | 25b. REGISTRAR'S SIGNATURE  |  |
| Frampton-Hawkins Funeral Home  |   | 216 N. Main St.   |   | DEC 18 1979   |   | [Signature]   |  |

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF, MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death and may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

7 9 3 0 5 3 6

1- FOR  
STATE  
REGISTRAR

REG. NO.

|  |  |   |  |  |   |  |   |  |   |  |
|--|--|---|--|--|---|--|---|--|---|--|
| 1 DECEASED NAME<br>(TYPE OR PRINT)<br><b>Baby Boy QUIJADA</b>  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>December 7 1979</b>            |  |   | 2b. HOUR<br><b>8:10A M</b>   |   |  |   |  |
| 3 SEX<br><b>Male</b>   |  | 4 RACE<br><b>White</b>  |  | 5 DATE OF BIRTH<br>MONTH DAY YEAR<br><b>12 7 79</b>  |   | 6 AGE (IN YEARS LAST BIRTHDAY)<br>YRS. MONTHS DAYS<br><b>6 4</b>   |   | 7 UNDER 1 YEAR<br>HOURS MIN<br><b>6 4</b>  |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.   |   |  |   |  |
| 10 CITY OR TOWN OF DEATH<br><b>Baltimore</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Maryland General Hospital</b> |  |  |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>none</b>  |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>none</b>   |   |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>Virginia</b>   |  |   | 13b. COUNTY<br><b>Arlington</b>  |  | 13c. CITY OR TOWN<br><b>Arlington</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>2300 S. 24th Road 22006</b> |  |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Antonio Pelxoto</b>  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Migdalia Quijada</b> |  |   |  |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>no</b>  |  |   | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)                  |  | 17 INFORMANT<br>ADDRESS<br><b>Medical Records<br/>Maryland General Hospital 827 Linden Avenue</b> |  |   |  |   |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <b>Respiratory Failure</b><br><b>769-</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>Severe Hyaline Newborn Disease</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Prematurity 26 Weeks Gestational Age</b><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |   |  |  |   |  |   |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)  |  |   |  |  |   |  |   |  |   |  |
| 19a. DATE OF OPERATION   |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                         |  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19               |  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |   |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |   |  |   |  |
| 22a. I certify that the hospital attended the deceased from <b>December 7 19 79</b> , to <b>December 7 19 79</b> , that (1) <input checked="" type="checkbox"/> I saw the deceased alive on <b>December 7 19 79</b> , and that in (my) <input checked="" type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above. If <input type="checkbox"/> did (or did not) view the body after death.   |  |   |  |  |   |  |   |  |   |  |
| 22b. SIGNATURE<br><b>Mario Gonzalez, M.D.</b>  |  |   |  |  |   | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |   | 22c. DATE SIGNED<br><b>12-7-79</b>   |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Mario Gonzalez, M.D.</b>   |  |   |  |  |   | 22e. ADDRESS<br><b>c/o Maryland General Hospital</b>   |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Removal</b>   |  |   | 23b. DATE<br><b>12/13/79</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE  |  |   |  |
| 24 FUNERAL DIRECTOR<br>NAME<br><b>Anatomy Board</b>  |  |   |  |  |   | ADDRESS<br><b>Balto., Md.</b>  |   | 25a. DATE REC'D. BY REGISTRAR<br><b>DEC 17 1979</b>  |   |  |
|  |  |   |  |  |   | 25b. REGISTRAR'S SIGNATURE<br><b>Anthony McCreedy</b>  |   |  |   |  |



**TO MEDICAL EXAMINER:** THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, INDICATE THE REASON THEREFOR. AFTER DEATH, WRITING THE WORD "PENDING" IN EXAMINER ITEM 18, GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES.

**TO FUNERAL DIRECTOR:** PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

1- FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO 30537

|  |  |         |  |  |  |                   |  |  |  |                  |  |   |  |       |  |  |  |      |  |                    |  |  |  |
|--|--|---------|--|--|--|-------------------|--|--|--|------------------|--|---|--|-------|--|--|--|------|--|--------------------|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  | FIRST   |  | MIDDLE   |  | LAST              |  | 2a. DATE KNOWN OF DEATH  |  | MONTH            |  | DAY   |  | YEAR  |  | 2b. HOUR                                     |  |      |  |                    |  |  |  |
| GARDNER  |  |         |  |  |  | QUINN             |  | <input checked="" type="checkbox"/> 12   |  | 30               |  | 19  |  | 79    |  | a  |  |      |  |                    |  |  |  |
| 3. SEX   |  | 4. RACE |  | 5. DATE OF BIRTH   |  | 6. AGE (IN YEARS) |  | IF UNDER 1 YR.   |  | IF UNDER 24 HRS. |  | 7c. DATE PRONOUNCED DEAD  |  | MONTH |  | DAY  |  | YEAR |  | 2d. HOUR           |  |  |  |
| male   |  | negro   |  | 12 5 24  |  | 55 YRS.           |  | MONTHS   |  | DAYS             |  | HOURS   |  | MIN.  |  | 12   |  | 30   |  | 1979               |  |  |  |
| 10. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  |         |  | 7b. CITIZEN OF WHAT COUNTRY?   |  |                   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |                  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |  |       |  |  |  |      |  |                    |  |  |  |
| Baltimore, Md.   |  |         |  | USA  |  |                   |  |  |  |                  |  | Baltimore City  |  |       |  |  |  |      |  |                    |  |  |  |
| 10. CITY OR TOWN OF DEATH  |  |         |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)                            |  |                   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |  |                  |  | 12b. KIND OF BUSINESS OR INDUSTRY                                   |  |       |  |  |  |      |  |                    |  |  |  |
| Baltimore  |  |         |  | 1821 Madison Ave.  |  |                   |  | Laborer  |  |                  |  |   |  |       |  |  |  |      |  |                    |  |  |  |
| 13a. STATE   |  |         |  | 13b. COUNTY  |  |                   |  | 13c. CITY OR TOWN  |  |                  |  | 13d. INSIDE CITY LIMITS?  |  |       |  | 13e. STREET ADDRESS                          |  |      |  |                    |  |  |  |
| Md.  |  |         |  |  |  |                   |  | Balto.   |  |                  |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |       |  | 1100 Cleandine St.                           |  |      |  |                    |  |  |  |
| 14. FATHER'S NAME  |  |         |  | 15. MOTHER'S MAIDEN NAME   |  |                   |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?   |  |                  |  | 16b. SOCIAL SECURITY NO.  |  |       |  | 17. INFORMANT                                |  |      |  | ADDRESS            |  |  |  |
| Gardner  |  |         |  | Quinn  |  |                   |  | BIRDIE   |  |                  |  | NEWMAN  |  |       |  | LAWRENCE F. QUINN                            |  |      |  | 1100 Cleandine St. |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |  |         |  | PART I DEATH WAS CAUSED BY:  |  |                   |  | IMMEDIATE CAUSE (a)  |  |                  |  | DUE TO, OR AS A CONSEQUENCE OF                                      |  |       |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |      |  |                    |  |  |  |
| 5570   |  |         |  | Small bowel infarction   |  |                   |  |  |  |                  |  |   |  |       |  |  |  |      |  |                    |  |  |  |
| CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a) STATING THE UNDERLYING CAUSE LAST.  |  |         |  | (b)  |  |                   |  | DUE TO, OR AS A CONSEQUENCE OF   |  |                  |  | (c)   |  |       |  |  |  |      |  |                    |  |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).  |  |         |  |  |  |                   |  |  |  |                  |  |   |  |       |  |  |  |      |  |                    |  |  |  |
| 19a. DATE OF OPERATION   |  |         |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |  |                   |  |  |  |                  |  | 20. AUTOPSY?  |  |       |  | BODY ONLY                                    |  |      |  |                    |  |  |  |
|  |  |         |  |  |  |                   |  |  |  |                  |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |       |  |  |  |      |  |                    |  |  |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |  |         |  | 21b. TIME OF INJURY  |  |                   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)  |  |                  |  |   |  |       |  |  |  |      |  |                    |  |  |  |
|  |  |         |  | P.M. 19  |  |                   |  |  |  |                  |  |   |  |       |  |  |  |      |  |                    |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  |         |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)  |  |                   |  | 21f. LOCATION  |  |                  |  | CITY OR TOWN  |  |       |  | COUNTY                                       |  |      |  | STATE              |  |  |  |
|  |  |         |  |  |  |                   |  | BODY ONLY  |  |                  |  |   |  |       |  |  |  |      |  |                    |  |  |  |
| 22a. I certify that I took charge of the remains described above, held on death resulted from:   |  |         |  | Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion |  |                   |  |  |  |                  |  |   |  |       |  |  |  |      |  |                    |  |  |  |
| Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |  |         |  |  |  |                   |  |  |  |                  |  |   |  |       |  |  |  |      |  |                    |  |  |  |
| ACTUAL SIGNATURE   |  |         |  | TITLE (SPECIFY)  |  |                   |  | DATE SIGNED  |  |                  |  |   |  |       |  |  |  |      |  |                    |  |  |  |
| Ann M. Dixon, M.D.   |  |         |  | Assistant  |  |                   |  | 12-30-79   |  |                  |  |   |  |       |  |  |  |      |  |                    |  |  |  |
| EXAMINER'S NAME (TYPE OR PRINT)  |  |         |  | ADDRESS  |  |                   |  |  |  |                  |  |   |  |       |  |  |  |      |  |                    |  |  |  |
| Burial   |  |         |  | 1-3-80   |  |                   |  | Mt. Auburn   |  |                  |  | Baltimore   |  |       |  | Md.  |  |      |  |                    |  |  |  |
| 24. FUNERAL DIRECTOR   |  |         |  | 25a. DATE REC'D. BY REGISTRAR  |  |                   |  | 25b. REGISTRAR'S SIGNATURE   |  |                  |  |   |  |       |  |  |  |      |  |                    |  |  |  |
| William C. Blawie  |  |         |  | 1206-08 W. York Ave.   |  |                   |  | DEC 31 1979  |  |                  |  | Anthony McCreedy  |  |       |  |  |  |      |  |                    |  |  |  |

1303 BP \_\_\_\_\_  
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UNCLASSIFIED - SECURITY INFORMATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  |  |  |  |  |   |  |
|---|--|--|--|--|--|--|--|---|--|
| 1. FOR STATE REGISTRAR  |  | 7 9 3 0 5 3 8<br>REG. NO.  |  |  |  |  |  |   |  |
| 1. DECEASED NAME (TYPE OR PRINT)  |  | FIRST<br>OTTO  |  | MIDDLE<br>C.   |  | LAST<br>RABE   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>12-26-79 |  |
| 3 SEX<br>MALE   |  | 4 RACE<br>WHITE  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>OCTOBER 31, 1894   |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br>85 YRS   |  | 7b. HOUR<br>11:00PM                             |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>GERMANY  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY, MD.   |  |   |  |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE, MD.   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>CHURCH HOSPITAL, INC. |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>RETIRED  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>MACHINIST   |  |   |  |
| 13a. STATE<br>MD.   |  | 13b. COUNTY<br>BALTIMORE   |  | 13c. CITY OR TOWN<br>BALTIMORE   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |  | 13e. STREET ADDRESS<br>3219 FOSTER AVE. # 21224 |  |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br>? RABE   |  | 15 MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>UNKNOWN  |  |  |  |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>NO  |  | 16b. SOCIAL SECURITY NO<br>(IF YES, GIVE WAR OR DATES)<br>214-01-3053  |  | 17 INFORMANT<br>HILDA RABE ;   |  | ADDRESS<br>3219 FOSTER AVE.<br>BALTIMORE, 21224, MD.   |  |   |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY.<br>IMMEDIATE CAUSE (a) CARDIAC ASYSTOLE<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) ANTEROSEPTAL MIOCARDIAL INFARCTION<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) 410-<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>30 MINUTES<br>7 DAYS |  |  |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH    |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE, BILATERAL PNEUMONIA, HEART FAILURE   |  |  |  |  |  |  |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED<br>(ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |  |  |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |  |  |   |  |
| 22a. I certify that (1) this hospital attended the deceased from 12-26 19 79, to 12-26 19 79, that (2) we last saw the deceased alive on 12-26 19 79, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (If we did) did not view the body after death.   |  |  |  |  |  |  |  |   |  |
| 22b. SIGNATURE<br><i>Adolfo Lopez</i>   |  | DEGREE   |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                            |  | 22c. DATE SIGNED<br>12-26-79   |  |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>DR. ADOLFO LOPEZ   |  | 22e. ADDRESS<br>XXX 100 N. BROADWAY CHURCH HOSPITAL CORPORATION, BALTIMORE, MARYLAND 21231   |  |  |  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>BURIAL   |  | 23b. DATE<br>12-31-79  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>SACRED HEART CEMETERY  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>7401 GERMAN HILL RD., BA. CO., MD.   |  |   |  |
| 24 FUNERAL DIRECTOR<br>NAME<br>Charles S. Geiler & Son, Inc.  |  | 401 S. CONKLING ST.<br>BALTO., 21224, MD.  |  | 25a. DATE REC'D BY REGISTRAR<br>JAN 1 1980   |  | 25b. REGISTRAR'S SIGNATURE<br><i>Charles S. Geiler</i>   |  |   |  |

1940

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CHURCH ST. 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100, 101, 102, 103, 104, 105, 106, 107, 108, 109, 110, 111, 112, 113, 114, 115, 116, 117, 118, 119, 120, 121, 122, 123, 124, 125, 126, 127, 128, 129, 130, 131, 132, 133, 134, 135, 136, 137, 138, 139, 140, 141, 142, 143, 144, 145, 146, 147, 148, 149, 150, 151, 152, 153, 154, 155, 156, 157, 158, 159, 160, 161, 162, 163, 164, 165, 166, 167, 168, 169, 170, 171, 172, 173, 174, 175, 176, 177, 178, 179, 180, 181, 182, 183, 184, 185, 186, 187, 188, 189, 190, 191, 192, 193, 194, 195, 196, 197, 198, 199, 200, 201, 202, 203, 204, 205, 206, 207, 208, 209, 210, 211, 212, 213, 214, 215, 216, 217, 218, 219, 220, 221, 222, 223, 224, 225, 226, 227, 228, 229, 230, 231, 232, 233, 234, 235, 236, 237, 238, 239, 240, 241, 242, 243, 244, 245, 246, 247, 248, 249, 250, 251, 252, 253, 254, 255, 256, 257, 258, 259, 260, 261, 262, 263, 264, 265, 266, 267, 268, 269, 270, 271, 272, 273, 274, 275, 276, 277, 278, 279, 280, 281, 282, 283, 284, 285, 286, 287, 288, 289, 290, 291, 292, 293, 294, 295, 296, 297, 298, 299, 300, 301, 302, 303, 304, 305, 306, 307, 308, 309, 310, 311, 312, 313, 314, 315, 316, 317, 318, 319, 320, 321, 322, 323, 324, 325, 326, 327, 328, 329, 330, 331, 332, 333, 334, 335, 336, 337, 338, 339, 340, 341, 342, 343, 344, 345, 346, 347, 348, 349, 350, 351, 352, 353, 354, 355, 356, 357, 358, 359, 360, 361, 362, 363, 364, 365, 366, 367, 368, 369, 370, 371, 372, 373, 374, 375, 376, 377, 378, 379, 380, 381, 382, 383, 384, 385, 386, 387, 388, 389, 390, 391, 392, 393, 394, 395, 396, 397, 398, 399, 400, 401, 402, 403, 404, 405, 406, 407, 408, 409, 410, 411, 412, 413, 414, 415, 416, 417, 418, 419, 420, 421, 422, 423, 424, 425, 426, 427, 428, 429, 430, 431, 432, 433, 434, 435, 436, 437, 438, 439, 440, 441, 442, 443, 444, 445, 446, 447, 448, 449, 450, 451, 452, 453, 454, 455, 456, 457, 458, 459, 460, 461, 462, 463, 464, 465, 466, 467, 468, 469, 470, 471, 472, 473, 474, 475, 476, 477, 478, 479, 480, 481, 482, 483, 484, 485, 486, 487, 488, 489, 490, 491, 492, 493, 494, 495, 496, 497, 498, 499, 500, 501, 502, 503, 504, 505, 506, 507, 508, 509, 510, 511, 512, 513, 514, 515, 516, 517, 518, 519, 520, 521, 522, 523, 524, 525, 526, 527, 528, 529, 530, 531, 532, 533, 534, 535, 536, 537, 538, 539, 540, 541, 542, 543, 544, 545, 546, 547, 548, 549, 550, 551, 552, 553, 554, 555, 556, 557, 558, 559, 560, 561, 562, 563, 564, 565, 566, 567, 568, 569, 570, 571, 572, 573, 574, 575, 576, 577, 578, 579, 580, 581, 582, 583, 584, 585, 586, 587, 588, 589, 590, 591, 592, 593, 594, 595, 596, 597, 598, 599, 600, 601, 602, 603, 604, 605, 606, 607, 608, 609, 610, 611, 612, 613, 614, 615, 616, 617, 618, 619, 620, 621, 622, 623, 624, 625, 626, 627, 628, 629, 630, 631, 632, 633, 634, 635, 636, 637, 638, 639, 640, 641, 642, 643, 644, 645, 646, 647, 648, 649, 650, 651, 652, 653, 654, 655, 656, 657, 658, 659, 660, 661, 662, 663, 664, 665, 666, 667, 668, 669, 670, 671, 672, 673, 674, 675, 676, 677, 678, 679, 680, 681, 682, 683, 684, 685, 686, 687, 688, 689, 690, 691, 692, 693, 694, 695, 696, 697, 698, 699, 700, 701, 702, 703, 704, 705, 706, 707, 708, 709, 710, 711, 712, 713, 714, 715, 716, 717, 718, 719, 720, 721, 722, 723, 724, 725, 726, 727, 728, 729, 730, 731, 732, 733, 734, 735, 736, 737, 738, 739, 740, 741, 742, 743, 744, 745, 746, 747, 748, 749, 750, 751, 752, 753, 754, 755, 756, 757, 758, 759, 760, 761, 762, 763, 764, 765, 766, 767, 768, 769, 770, 771, 772, 773, 774, 775, 776, 777, 778, 779, 780, 781, 782, 783, 784, 785, 786, 787, 788, 789, 790, 791, 792, 793, 794, 795, 796, 797, 798, 799, 800, 801, 802, 803, 804, 805, 806, 807, 808, 809, 810, 811, 812, 813, 814, 815, 816, 817, 818, 819, 820, 821, 822, 823, 824, 825, 826, 827, 828, 829, 830, 831, 832, 833, 834, 835, 836, 837, 838, 839, 840, 841, 842, 843, 844, 845, 846, 847, 848, 849, 850, 851, 852, 853, 854, 855, 856, 857, 858, 859, 860, 861, 862, 863, 864, 865, 866, 867, 868, 869, 870, 871, 872, 873, 874, 875, 876, 877, 878, 879, 880, 881, 882, 883, 884, 885, 886, 887, 888, 889, 890, 891, 892, 893, 894, 895, 896, 897, 898, 899, 900, 901, 902, 903, 904, 905, 906, 907, 908, 909, 910, 911, 912, 913, 914, 915, 916, 917, 918, 919, 920, 921, 922, 923, 924, 925, 926, 927, 928, 929, 930, 931, 932, 933, 934, 935, 936, 937, 938, 939, 940, 941, 942, 943, 944, 945, 946, 947, 948, 949, 950, 951, 952, 953, 954, 955, 956, 957, 958, 959, 960, 961, 962, 963, 964, 965, 966, 967, 968, 969, 970, 971, 972, 973, 974, 975, 976, 977, 978, 979, 980, 981, 982, 983, 984, 985, 986, 987, 988, 989, 990, 991, 992, 993, 994, 995, 996, 997, 998, 999, 1000

12-21-73  
201 N. COMPTON ST.  
CHICAGO, ILL. 60612



DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

7 9 3 0 5 3 9

REG. NO.

FOR  
STATE  
REGISTRAR

|   |   |  |  |  |  |
|---|---|--|--|--|--|
| 1 DECEASED NAME<br>(TYPE OR PRINT)<br>Bertha Frances Raine  |   | 2a DATE OF DEATH<br>MONTH DAY YEAR<br>December 30, 1979  |  | 2b HOUR AM<br>6:00 M   |  |
| 3 SEX<br>Female   | 4 RACE<br>White   | 5 DATE OF BIRTH<br>Nov. 30, 1883   | 6 AGE (IN YEARS LAST BIRTHDAY)<br>96   | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN   |  |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>New Jersey  | 7b CITIZEN OF WHAT COUNTRY?<br>USA  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9 BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.                    |  |  |
| 10 CITY OR TOWN OF DEATH<br>Baltimore   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>721 N. Lakewood Ave. |  | 12a USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Homemaker | 12b KIND OF BUSINESS OR INDUSTRY<br>-  |  |
| 13a STATE<br>Maryland   |   | 13b COUNTY<br>-  | 13c CITY OR TOWN<br>Baltimore  | 13d INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>       | 13e STREET ADDRESS<br>721 N. Lakewood Ave.   |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br>Warren - Ayers   |   | 15 MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Anna - Rocap   |  |  |  |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No   |   | 16b SOCIAL SECURITY NO.<br>-   | 17 INFORMANT<br>ADDRESS same address<br>Grace Hackett, granddaughter,        |  |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Myocardial Infarct</u><br>410-<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(c) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>Minutes</u> |   |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):  |   |  |  |  |  |
| 19a DATE OF OPERATION   |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                             | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                       |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 19 <u>77</u> to <u>12</u> 19 <u>79</u> that (I) (we) last saw the deceased alive on <u>11</u> 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If yes) (did) (did not) view the body after death.  |   |  |  |  |  |
| 22b. SIGNATURE<br><u>Dr. Dennis MacDonald</u>   |   | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>       |  | 22c. DATE SIGNED<br>12/31/79   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Dr. Dennis MacDonald   |   | 22e. ADDRESS<br>9 S. Highland Ave.   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial   |   | 23b. DATE<br>Jan. 2, 1980  | 23c. NAME OF CEMETERY OR CREMATORY<br>Parkwood Cem.                          |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore Maryland   |
| 24. FUNERAL DIRECTOR<br>Schimunek Funeral Home, Inc.  |   | ADDRESS<br>3331 Brehms Lane<br>Balto., Md. 21213   |  | 25a. DATE REC'D. BY REGISTRAR<br>JAN 3 1980<br>25b. REGISTRAR'S SIGNATURE<br><u>Dennis MacDonald</u> |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed in the office of the Registrar after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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RECEIVED



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Vertical handwritten text on the left margin.

Large handwritten signature or name in the center.

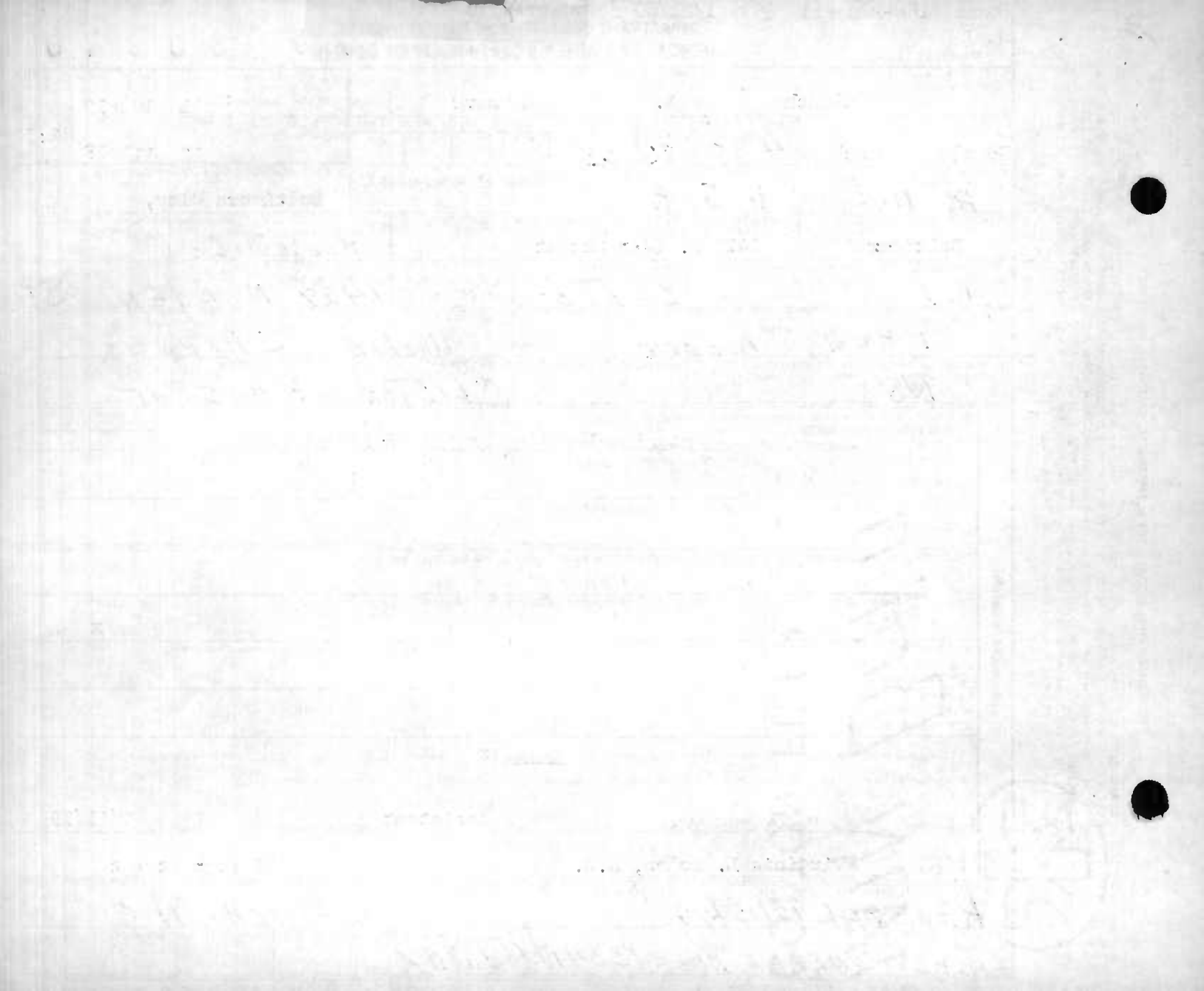
Handwritten text at the bottom left corner.

JAN 1 1960

RECEIVED

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS ANTICIPATED, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PA 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH   |  |                         |  |  |  |   |  |   |  | REG. NO. 30540   |  |                             |  |
|--|--|-------------------------|--|--|--|---|--|---|--|--|--|-----------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Blanche E. Ramseur</b>  |  |                         |  |  |  |   |  |   |  | 2a. DATE OF DEATH<br>KNOWN <input type="checkbox"/> ESTIMATED <input checked="" type="checkbox"/> <b>12 10 19 79</b> |  | 2b. HOUR<br><b>2:57 A M</b> |  |
| 3. SEX<br><b>Female</b>  |  | 4. RACE<br><b>Black</b> |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR <b>4 2 26 53 YRS.</b>   |  | 6. AGE (IN YEARS)<br>LAST BIRTHDAY <b>53 YRS.</b>   |  | IF UNDER 1 YR.<br>MONTHS DAYS HOURS MIN   |  | IF UNDER 24 HRS.<br>HOURS MIN  |  |                             |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>AL N.C.</b>  |  |                         |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A</b>   |  |   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City, MD.</b>   |  |                             |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |  |                         |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>1428 N. Eden Street</b> |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Housewife</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |                             |  |
| 13a. STATE<br><b>md</b>  |  |                         |  | 13b. COUNTY<br><b>BALTO.</b>   |  | 13c. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>1428 N. EDEN ST</b>   |  |  |  |                             |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>I-R E D M O O R E</b>   |  |                         |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>U N S H I E S H I P P E R</b>               |  |   |  |  |  |                             |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br><b>No</b>   |  |                         |  | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT<br>ADDRESS<br><b>CLIFTON RAMSEUR</b>  |  |   |  |  |  |                             |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br><b>4292 IMMEDIATE CAUSE (a) Arteriosclerotic Cardiovascular Disease</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b)<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)   |  |                         |  |  |  |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |                             |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).  |  |                         |  |  |  |   |  |   |  |  |  |                             |  |
| 19a. DATE OF OPERATION   |  |                         |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |  |   |  |   |  | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                  |  |                             |  |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |  |                         |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)                   |  |   |  |  |  |                             |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |                         |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |  |  |                             |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . |  |                         |  |  |  |   |  |   |  |  |  |                             |  |
| ACTUAL SIGNATURE<br><b>Virginia L. Dolan</b>   |  |                         |  | TITLE (SPECIFY)<br><b>Assistant</b>  |  |   |  | DATE SIGNED<br><b>12/11/79</b>  |  |  |  |                             |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT)<br><b>Virginia L. Dolan, M.D.</b>   |  |                         |  | ADDRESS<br><b>111 Penn Street</b>  |  |   |  |   |  |  |  |                             |  |
| 23a. BURIAL, CREMATION, REMOVAL<br><b>REMOVAL</b>  |  |                         |  | 23b. DATE<br><b>12/15/79</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY  |  |   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>MAIDEN N.C.</b>   |  |                             |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>LOCKS FUNERAL HOME</b>  |  |                         |  | ADDRESS<br><b>1304 N. Central</b>  |  |   |  | 25. DATE REC'D. BY REGISTRAR  |  | 25b. REGISTRAR'S SIGNATURE   |  |                             |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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13

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

79 30541

|   |  |   |  |  |  |  |  |  |  |  |     |   |                        |   |  |
|---|--|---|--|--|--|--|--|--|--|--|-----|---|------------------------|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |  | FIRST   |  | MIDDLE   |  | LAST   |  | 2a. DATE OF DEATH  |  | MONTH  | DAY | YEAR  | 2b. HOUR               |   |  |
| Blanchard   |  |   |  |  |  | RANDALL  |  | Dec. 14  |  |  |     | 1979  | 10 <sup>15</sup> P. M. |   |  |
| 3 SEX   |  | 4 RACE  |  | 5 DATE OF BIRTH  |  | 6 AGE (IN YEARS LAST BIRTHDAY)   |  | 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  | 7b. CITIZEN OF WHAT COUNTRY?                               |     | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>  |                        | 9 BALTIMORE CITY OR COUNTY OF DEATH   |  |
| Male  |  | White   |  | Mar. 28 1894   |  | 85 YRS.  |  | Md.  |  | U.S.A.   |     |   |                        | Baltimore City MD.  |  |
| 10 CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)                     |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  | 13a. STATE   |  | 13b. COUNTY  |     | 13c. CITY OR TOWN   |                        | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                     |  |
| Ba lto.   |  | 5706 Kenmore Rd.  |  | Executive  |  | Cemetery   |  | Md.  |  |  |     | Balto.  |                        |   |  |
| 14 FATHER'S NAME  |  | 15 MOTHER'S MAIDEN NAME   |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)                 |  | 16b. SOCIAL SECURITY NO  |  | 17 INFORMANT   |  | 17 ADDRESS   |     | 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <u>CARCINOMATOSIS</u><br>1539<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) <u>CARCINOMA OF COLON</u><br>(c) <u></u><br>DUE TO, OR AS A CONSEQUENCE OF<br>DUE TO, OR AS A CONSEQUENCE OF<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>3 MOS<br>? |                        | PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) |  |
| Blanchard   |  | Susan   |  | Yes  |  | WW 1   |  | 215-07-3372  |  | Blanchard Randall 111                                      |     | Balto., Md.   |                        |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER) |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19 |     | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |                        | 21d. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  |
|   |  |   |  |  |  |  |  |  |  |  |     |   |                        |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>DEC 14</u> 19 <u>79</u> , and that in (my) <u>own</u> opinion death occurred on the date and hour and from the causes stated above, (I) <u>did</u> (did not) view the body after death. |  | 22b. SIGNATURE<br><u>John M. Scott M.D.</u>   |  | 22c. DATE SIGNED<br>12/15/79   |  | 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  | 22e. ADDRESS   |  | 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)                  |     | 23b. DATE   |                        | 23c. NAME OF CEMETERY OR CREMATORY  |  |
|   |  |   |  |  |  | John M. Scott M.D.   |  | 600 W. Northern Parkway, Balto., Md.   |  | Cremation  |     | 12-17-79  |                        | Greenmount  |  |
| 24 FUNERAL DIRECTOR<br>NAME   |  | 24 ADDRESS  |  | 25a. DATE REC'D. BY REGISTRAR  |  | 25b. REGISTRAR'S SIGNATURE   |  | 26a. LOCATION<br>CITY OR TOWN  |  | 26b. COUNTY  |     | 26c. STATE  |                        | 27. DATE REC'D. BY REGISTRAR  |  |
| Henry W. Jenkins & Sons Co., Balto., Md.  |  | 4905 York Rd.   |  | DEC 17 1979  |  | <u>John M. Scott</u>   |  | Balto.   |  | Md.  |     |   |                        |   |  |

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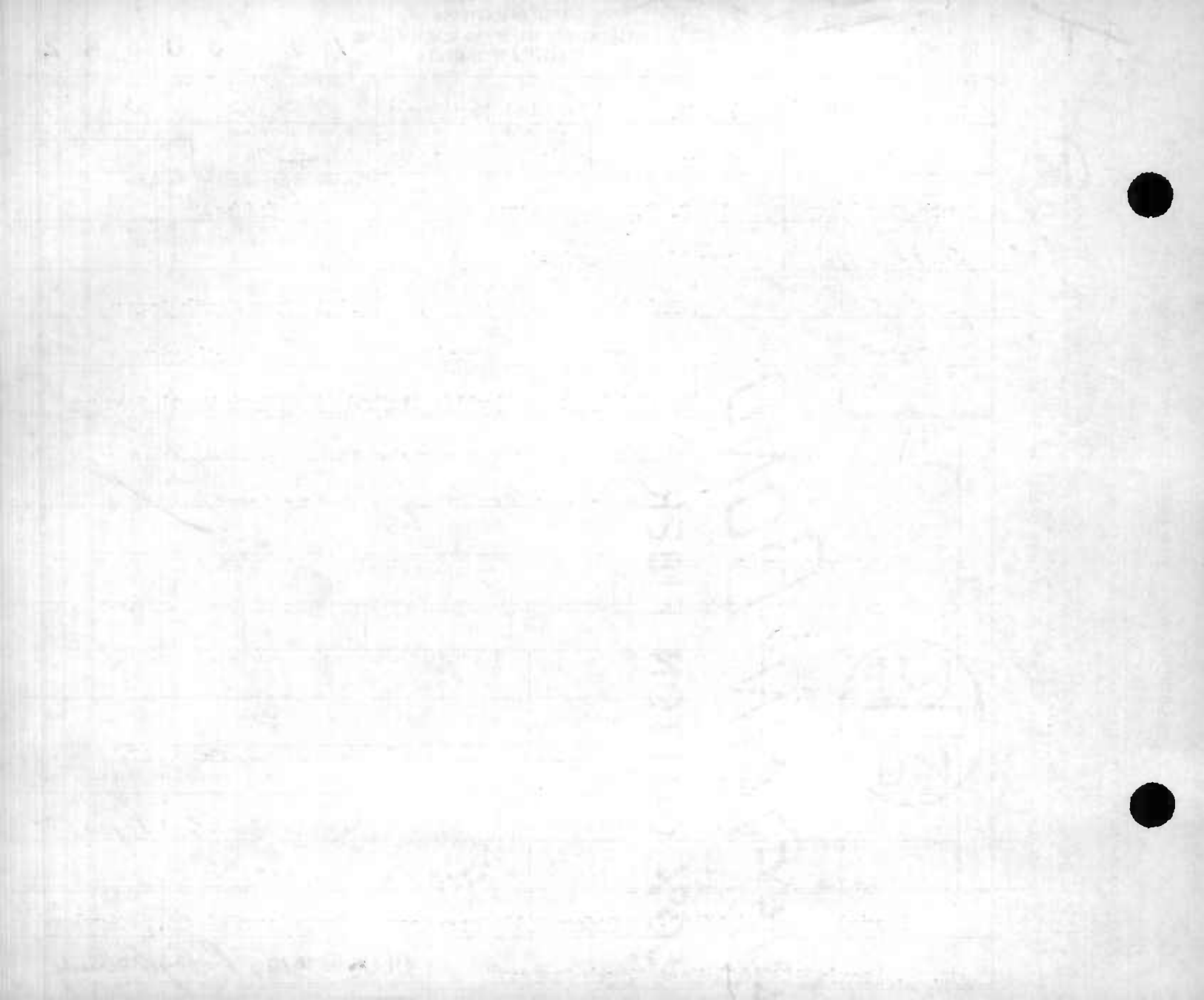


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| #6, per F.H. 1/3/80 kam   |  |  |  | STATE OF MARYLAND   |  |  |  |
|---|--|--|--|---|--|--|--|
| 1 - STATE REGISTRAR   |  |  |  | DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  |  |  |
| 1 - STATE REGISTRAR   |  |  |  | 7 9 3 0 5 4 2   |  |  |  |
| 1 DECEASED NAME (TYPE OR PRINT)   |  |  |  | 2a. DATE OF DEATH   |  |  |  |
| Mamie (Ramison) M. (Mammie) Ranison   |  |  |  | 12 16 79  |  |  |  |
| 3 SEX   |  | 4 RACE   |  | 5 DATE OF BIRTH   |  | 6 AGE (IN YEARS LAST BIRTHDAY)                                 |  |
| Female  |  | Negro  |  | 7 8 1905  |  | 64-74 YRS  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH                            |  |
| South Carolina  |  | U. S. A.   |  |   |  | Balt'o Md  |  |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)   |  | 12b. KIND OF BUSINESS OR INDUSTRY                              |  |
| Baltimore   |  | Provident Hospital   |  |   |  |  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |  |  | 13d. INSIDE CITY LIMITS?  |  |  |  |
| 13a. STATE  |  |  |  | 13b. COUNTY   |  |  |  |
| Maryland  |  |  |  | Baltimore   |  |  |  |
| 14 FATHER'S NAME  |  |  |  | 15 MOTHER'S MAIDEN NAME   |  |  |  |
| George M. Brown   |  |  |  | Martha Weatherly  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)   |  |  |  | 16b. SOCIAL SECURITY NO.  |  | 17 INFORMANT ADDRESS   |  |
|   |  |  |  | 249-14-7339   |  | Phyllis McLeod 2771 West North Avenue                          |  |
| 18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)   |  |  |  |   |  |  |  |
| PART I. DEATH WAS CAUSED BY:  |  |  |  |   |  |  |  |
| IMMEDIATE CAUSE (a) <u>Cardiopulmonary Arrest</u>   |  |  |  |   |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF (b) <u>Melanotic Ca of Pancreas</u>  |  |  |  |   |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF (c) <u></u>  |  |  |  |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |  |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |  |
|   |  |  |  | YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | YES <input type="checkbox"/> NO <input type="checkbox"/>       |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |
|   |  | P.M. 19  |  |   |  |  |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |  |  |
|   |  |  |  |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>12/17</u> , 19 <u>79</u> , to <u>12/16</u> , 19 <u>79</u> , that (I) (we) lost saw the deceased alive on <u>12/16</u> , 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. |  |  |  |   |  |  |  |
| 22b. SIGNATURE  |  |  |  | DEGREE  |  | 22c. DATE SIGNED   |  |
| <u>Ronald D. Miles, M.D.</u>  |  |  |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>              |  | 12/16/79   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  |  |  | 22e. ADDRESS  |  |  |  |
| <u>Ronald D. Miles, M.D.</u>  |  |  |  | <u>Provident Hosp</u>   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE                        |  |
| Burial  |  | 12/21/1979   |  | Cedar Hill Cemetery   |  | Anne Arundel Co., Maryland                                     |  |
| 24. FUNERAL DIRECTOR NAME   |  |  |  | 25a. DATE REC'D. BY REGISTRAR   |  | 25b. REGISTRAR'S SIGNATURE                                     |  |
| Wm. C. March F/H 1101 East North Avenue   |  |  |  | DEC 18 1979   |  | <u>Dorothy McCreedy</u>  |  |





Item #100 per phone call w/Run. HO STATE OF MARYLAND  
 1 - FOR 1/25/80 rc  
 STATE REGISTRAR  
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
 CERTIFICATE OF DEATH

REG. NO.

7 9 3 0 5 4 3

|  |  |  |  |   |  |  |  |
|--|--|--|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>PAUL Paul</b>  |  | FIRST MIDDLE LAST<br><b>RAUGH</b>  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>12 14 79</b>  |  | 2b. HOUR<br><b>4 P</b>   |  |
| 3 SEX<br><b>Male</b>   |  | 4 RACE<br><b>White</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>8 27 1925</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>54 YRS.</b>  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. <b>BALTIMORE CITY</b> OR COUNTY OF DEATH<br><b>Baltimore City MD.</b>   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Baltimore City Hospitals</b> |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Supervisor</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Construction</b>   |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>Maryland</b>   |  |  |  | 13b. COUNTY<br><b>Baltimore</b>   |  | 13c. CITY OR TOWN<br><b>Baltimore</b>  |  |
| 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  |  |  | 13e. STREET ADDRESS<br><b>336 Joplin Street</b>   |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Paul Noah Raugh</b>   |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Frances Amy Barnes</b>  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>Yes</b>   |  |  |  | 16b. SOCIAL SECURITY NO.<br><b>262-44-4706</b>  |  | 17. INFORMANT<br>ADDRESS<br><b>336 Joplin St.<br/>Balto. MD 21224</b>  |  |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Hypertension,</b><br><b>410-</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Inf. MI.</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(c) _____<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><b>COMA</b> |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>Nov. 28</b> , 19 <b>79</b> , to <b>Dec 12</b> , 19 <b>79</b> , that (I) (we) last saw the deceased alive on <b>12/14</b> , 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death.   |  |  |  |   |  |  |  |
| 22b. SIGNATURE<br><b>Michael Wagner</b>  |  |  |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>        |  | 22c. DATE SIGNED<br><b>12/14/79</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>MICHAEL WAGNER</b>   |  |  |  | 22e. ADDRESS<br><b>BALTO. CITY HOSPITAL</b>   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>12/17/79</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Oak Lawn Cemetery</b>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore, Baltimore, MD</b>  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Duda-Ruck, Inc.</b><br><b>7922 Wise Avenue, Dundalk, MD 21222</b>   |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>DEC 18 1979</b>   |  |  |  |
|  |  |  |  | 25b. REGISTRAR'S SIGNATURE<br><b>Henry McLeod</b>   |  |  |  |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

UNITED STATES DEPARTMENT OF THE INTERIOR  
BUREAU OF LAND MANAGEMENT  
WASHINGTON, D. C. 20250

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

7 9 3 0 5 4 4

|   |  |   |  |  |  |  |   |  |  |
|---|--|---|--|--|--|--|---|--|--|
| 1 DECEASED NAME<br>(TYPE OR PRINT)<br>John Ignatius Raum  |  |   | 2a DATE OF DEATH<br>MONTH DAY YEAR<br>12 17 79                         |  |  | 2b HOUR<br>1:40p M   |   |  |  |
| 3 SEX<br>Male   |  | 4 RACE<br>Cauc  |  | 5 DATE OF BIRTH<br>MONTH DAY YEAR<br>10 16 1900  |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br>79   |   | 7 UNDER 1 YEAR<br>MONTHS DAYS<br>HOURS MIN   |  |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Md  |  | 7b CITIZEN OF WHAT COUNTRY?<br>USA  |  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD.  |   |  |  |
| 10 CITY OR TOWN OF DEATH<br>BALTIMORE   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>ST AGNES |  |  |  | 12a USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Machine Operator  |   | 12b KIND OF BUSINESS OR INDUSTRY<br>Beth. Steel  |  |
| 13a STATE<br>Maryland   |  |   | 13b COUNTY<br>Balto.   |  | 13c INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13d STREET ADDRESS<br>308 N. Chapelgate Lane                |  |  |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br>John J. Raum   |  |   | 15 MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Margaret Madeline Long |  |  |  |   |  |  |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No   |  |   | 16b SOCIAL SECURITY NO<br>(IF YES, GIVE WAR OR DATES)<br>217 03 3476   |  | 17 INFORMANT<br>ADDRESS<br>Mrs. Loretta R. Logsdon Balto., Md.                                 |  |   |  |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) Multiple system failure<br>5335<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) Septic shock<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) Perforated peptic ulcer |  |   |  |  |  |  |   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |   |  |  |  |  |   |  |  |
| 19a DATE OF OPERATION   |  |   | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED                        |  |  | 20a AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |   | 20b IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   | 21b TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19              |  |  | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |   |  |  |
| 21d INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |   | 21e PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  |  | 21f LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |  |  |
| 22a I certify that (this hospital) attended the deceased from Dec. 12 1979 to Dec. 17 1979, that (we) lost saw the deceased alive on above, (X) (we) (did not) view the body after death.   |  |   |  |  |  |  |   |  |  |
| 22b SIGNATURE<br>A. Zalduondo   |  |   | DEGREE<br>MD   |  |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |   | 22c DATE SIGNED<br>12/17/79  |  |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT)<br>Dr. Zalduondo   |  |   | 22e ADDRESS<br>St. Agnes Hospital, Balto., Md.                         |  |  |  |   |  |  |
| 23a BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial   |  |   | 23b DATE<br>12/20/79   |  | 23c NAME OF CEMETERY OR CREMATORY<br>New Cathedral   |  | 23d LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore, Md. |  |  |
| 24 FUNERAL DIRECTOR<br>NAME ADDRESS<br>Henry W. Jenkins & Sons Co.<br>4905 York Road Balto., Md. 21212  |  |   |  |  |  | 25a DATE REC'D. BY REGISTRAR<br>DEC 20 1979  |   | 25b REGISTRAR'S SIGNATURE<br>Dorothy McCready  |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 and 5 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified or called.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  |  |  |  |  |  |  |
|--|--|--|--|--|--|--|--|--|--|
| 1- FOR STATE REGISTRAR   |  |  |  |  |  |  |  |  |  |
| 1 DECEASED NAME<br>(TYPE OR PRINT) <b>PHEELUS R. RAY</b>   |  |  |  |  | 2a DATE OF DEATH<br>MONTH <b>12</b> DAY <b>17</b> YEAR <b>79</b>   |  |  |  |  |
| 3 SEX<br><b>MALE</b>   |  |  |  |  | 4 RACE<br><b>BLACK</b>   |  |  |  |  |
| 5 DATE OF BIRTH<br>MONTH <b>7</b> DAY <b>24</b> YEAR <b>23</b>   |  |  |  |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br><b>56</b> YRS  |  |  |  |  |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>BALTIMORE, Md.</b>  |  |  |  |  | 7b CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  |  |  |  |
| 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>   |  |  |  |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE, CITY</b> MD.  |  |  |  |  |
| 10 CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>   |  |  |  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Loch Raven Hospital VA</b> |  |  |  |  |
| 12a USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)  |  |  |  |  | 12b KIND OF BUSINESS OR INDUSTRY   |  |  |  |  |
| 13a STATE<br><b>MARYLAND</b>   |  |  |  |  | 13b COUNTY<br><b>Baltimore</b>   |  |  |  |  |
| 13c CITY OR TOWN<br><b>Baltimore</b>   |  |  |  |  | 13d INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  |  |  |  |
| 13e STREET ADDRESS<br><b>1435 HARFORD SQ.</b>  |  |  |  |  |  |  |  |  |  |
| 14. FATHER'S NAME<br>FIRST <b>Pheelus</b> MIDDLE <b>Ray</b> LAST <b>Sr.</b>  |  |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>Ethel</b> MIDDLE <b>Washington</b> LAST <b>Washington</b>   |  |  |  |  |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>YES</b>   |  |  |  |  | 16b SOCIAL SECURITY NO.<br><b>217 14 8235</b>  |  |  |  |  |
| 17 INFORMANT<br><b>Vivian Holloman</b>   |  |  |  |  | ADDRESS<br><b>1532 North Pulaski Street</b>  |  |  |  |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)<br>PART 1. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <b>ACUTE INFARCT LATERAL Myocardial Infarction</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>HYPERTENSION</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>410 -</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |  |  |  |  |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):   |  |  |  |  |  |  |  |  |  |
| 19a DATE OF OPERATION  |  |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  |  |  |
| 20a AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |  |  |  | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                  |  |  |  |  |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  |  |  |  |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |  |  |  | 21d INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                |  |  |  |  |
| 21e PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  |  |  |  | 21f LOCATION<br>STREET <b>3900 LOCH RAVEN BLVD., BALTO.</b> CITY OR TOWN <b>MD.</b> COUNTY <b>MD.</b> STATE <b>MD.</b>                     |  |  |  |  |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>12-17-</b> 19 <b>79</b> to <b>12-17</b> 19 <b>79</b> , that <input checked="" type="checkbox"/> (we) lost above <input type="checkbox"/> (we) (did) (did not) view the body after death.   |  |  |  |  |  |  |  |  |  |
| 22b. SIGNATURE<br><b>Harry Benson Hunt MD</b>  |  |  |  |  | 22c. DATE SIGNED<br><b>12/19/79</b>  |  |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Harry Benson Hunt MD</b>   |  |  |  |  | 22e ADDRESS<br><b>LRVA Hosp.</b>   |  |  |  |  |
| 23a. BURIAL, CREMATION REMOVAL (SPECIFY)<br><b>Cremation</b>   |  |  |  |  | 23b. DATE<br><b>12/21/1979</b>   |  |  |  |  |
| 23c. NAME OF CEMETERY OR CREMATORY<br><b>Westview Mem. Park</b>  |  |  |  |  | 23d. LOCATION<br>CITY OR TOWN <b>Catonsville, Maryland</b> COUNTY <b>Maryland</b> STATE <b>Maryland</b>                                    |  |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME <b>Wm. C. March F/H</b> ADDRESS <b>1101 East North Avenue</b>   |  |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>DEC 19 1979</b>  |  |  |  |  |
| 25b. REGISTRAR'S SIGNATURE<br><b>Harry Benson Hunt</b>   |  |  |  |  |  |  |  |  |  |

Y.D.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| FOR<br>1- STATE<br>REGISTRAR   |  |   |  | STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  | 7 9 3 0 5 4 6<br>REG. NO.  |  |  |  |
|--|--|---|--|---|--|---|--|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><i>REDIFER, P. ELEANOR</i>  |  |   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><i>12/20/79</i>  |  |   |  | 2b. HOUR<br><i>6:00 AM</i>   |  |  |  |
| 3. SEX<br><i>FEMALE</i>  |  | 4. RACE<br><i>WHITE</i>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><i>8-30-11</i>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><i>68</i> YRS.   |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS  |  | 8. IF UNDER 24 HRS<br>HOURS MIN                  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><i>MD.</i>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><i>U.S.A.</i>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><i>BALTO.</i> MD.   |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><i>BALTO., MD.</i>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><i>BON SECOURS HOSP.</i> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><i>UNEMPLOYED</i>   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><i>HOUSEWIFE</i>  |  |  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><i>MD.</i>   |  | 13b. COUNTY<br><i>BALTO.</i>  |  | 13c. CITY OR TOWN<br><i>BALTO.</i>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 13e. STREET ADDRESS<br><i>109 Ave. Montrose</i>  |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><i>EDWARD P. PENDLETON</i>   |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><i>Nellie S. Simmonds</i>  |  |   |  | 16. ADDRESS<br><i>109 Montrose Ave.</i>  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><i>No</i>  |  | 16b. SOCIAL SECURITY NO.<br><i>215-10-5297</i>  |  | 17. INFORMANT<br><i>George J. Redifer</i>   |  | 17a. ADDRESS<br><i>109 Montrose Ave.</i>  |  | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <i>Arrhythmia</i><br>4292<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <i>As a consequence of</i><br>(c) <i>As a consequence of</i> |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)<br><i>COPD - N.I.M. - U.T.I. - ARTERIO-SCLEROSIS</i> |  |   |  |   |  |   |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                 |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><i>P.M. 1979</i>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |  |   |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  | 22a. I certify that (I) (this hospital) attended the deceased from <i>11/10</i> , 19 <i>79</i> , to <i>12/20</i> , 19 <i>79</i> , that (I) (we) lost saw the deceased alive on <i>12/20</i> , 19 <i>79</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |
| 22b. SIGNATURE<br><i>George J. Redifer</i>   |  | DEGREE<br><i>MD.</i>  |  |   |  | 22c. DATE SIGNED<br><i>12/20/79</i>   |  | 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><i>Dr. George J. Redifer</i>  |  |  |  |
| 22e. ADDRESS<br><i>Baltimore, MD 21202</i>   |  | 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><i>Cremation</i>   |  |   |  |   |  |  |  |  |  |
| 23b. DATE<br><i>-12/21/79</i>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><i>Loudon Park Cemetery</i>   |  |   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><i>Baltimore, Md.</i>   |  |  |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><i>Sterling Funeral Estate</i>   |  |   |  | ADDRESS<br><i>736 Edmondson Ave.</i>  |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><i>DEC 24 1979</i>  |  | 25b. REGISTRAR'S SIGNATURE<br><i>[Signature]</i> |  |

BP \_\_\_\_\_





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 48 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at an office.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  |  |  |  |  |  |  |
|---|--|---|--|--|--|--|--|--|--|
| 1. FOR STATE REGISTRAR  |  | 7 9 3 0 5 4 7<br>REG. NO.   |  | 1. DECEASED NAME<br>(TYPE OR PRINT)<br>HARRY R REDMILES  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>12/30/79  |  | 2b. HOUR<br>5:02 P.M.  |  |
| 3 SEX<br>MALE   |  | 4 RACE<br>WHITE   |  | 5 DATE OF BIRTH<br>MONTH DAY YEAR<br>AUG 21 1911   |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br>68 YRS   |  | IF UNDER 1 YEAR<br>MONTHS DAYS   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>MD.  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |  | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD.  |  |  |  |
| 10 CITY OR TOWN OF DEATH<br>BALTIMORE   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>ST. AGNES HOSPITAL |  |  |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>MD. TIE.   |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>MD.   |  | 13b. COUNTY<br>BALTO.   |  | 13c. CITY OR TOWN  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 13e. STREET ADDRESS<br>5204 POWHATTAN  |  |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br>HARRY REDMILES   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>LAURA  |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) NO  |  |  |  |  |  |
| 16b. SOCIAL SECURITY NO.<br>217-14-1906   |  | 17 INFORMANT ADDRESS<br>MARY REDMILES 5204 POWHATTAN AVE.   |  |  |  |  |  |  |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) Respiratory Arrest<br>1629<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) Squamous Cell Carcinoma of the Lung 8 months<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)                         |  |   |  |  |  |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |   |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |  |  |  |  |
| 22a. I certify that (1) this hospital attended the deceased from Dec 15 19 79, to Dec 30 19 79, that (1) (we) last saw the deceased alive on Dec 30 19 79, and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) did (did not) view the body after death. |  |   |  |  |  |  |  |  |  |
| 22b. SIGNATURE<br>Charles E. Green MD   |  | DEGREE<br>MD  |  |  |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br>12/30/79   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Joseph Miller  |  | 22e. ADDRESS<br>900 CATON AVE. BALTIMORE, MD. 21229   |  |  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>BURIAL  |  | 23b. DATE<br>1-2-1980   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>NEW CATHEDRAL BALTO  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>BALTO MD.  |  |  |  |
| 24 FUNERAL DIRECTOR<br>NAME<br>WEBER FUNERAL HOME EDMONDSON   |  | ADDRESS<br>5311   |  | 25a. DATE REC'D. BY REGISTRAR<br>JAN 3 1980  |  | 25b. REGISTRAR'S SIGNATURE<br>Anthony M. Brady   |  |  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |                              |  |  |                                    |  |  |   |   |  |  |
|---|--|------------------------------|--|--|------------------------------------|--|--|---|---|--|--|
| 1. FOR STATE REGISTRAR  |  | 7 9 3 0 5 4 8                |  | REG. NO.   |                                    |  |  |   |   |  |  |
| 1. DECEASED NAME (TYPE OR PRINT)  |  |                              | FIRST MIDDLE LAST  |  |                                    | 2a. DATE OF DEATH MONTH DAY YEAR   |  |   | 2b. HOUR  |  |  |
| Isiah   |  |                              | Reed   |  |                                    | 12 1 79  |  |   | 7 30 PM   |  |  |
| 3. SEX  |  | 4. RACE                      |  | 5. DATE OF BIRTH MONTH DAY YEAR  |                                    | 6. AGE (IN YEARS LAST BIRTHDAY)  |  | IF UNDER 1 YEAR MONTHS DAYS             |   | IF UNDER 24 HRS. HOURS MIN.  |  |
| Male  |  | Black                        |  | 1 28 1895  |                                    | 84 YRS.  |  |   |   |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  | 7b. CITIZEN OF WHAT COUNTRY? |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                                    | 9. BALTIMORE CITY OR COUNTY OF DEATH   |  |   |   |  |  |
| Md  |  | USA                          |  |  |                                    | Baltimore City MD.   |  |   |   |  |  |
| 10. CITY OR TOWN OF DEATH   |  |                              | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |                                    | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |  |   | 12b. KIND OF BUSINESS OR INDUSTRY   |  |  |
| Balto.  |  |                              | Baltimore City Hospital  |  |                                    | Ret. Longshoreman  |  |   |   |  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |                              |  | 13a. STATE   |                                    | 13b. COUNTY  |  | 13c. CITY OR TOWN                       |   | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
|   |  |                              |  | Md   |                                    |  |  | Balto.                                  |   | 13e. STREET ADDRESS  |  |
|   |  |                              |  |  |                                    |  |  | 1432 Druid Hill Ave.                    |   |  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST   |  |                              |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST   |                                    |  |  |   |   |  |  |
| Dennis Reed   |  |                              |  | Kent   |                                    |  |  |   |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)   |  |                              |  | 16b. SOCIAL SECURITY NO.   |                                    | 17. INFORMANT ADDRESS  |  |   |   |  |  |
| No  |  |                              |  | 212 09 6673  |                                    | Wheeler Collins 2013 Braddish Ave.   |  |   |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cardiopulmonary arrest</u>  |  |                              |  |  |                                    |  |  |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |
| 3229 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Meningitis</u>   |  |                              |  |  |                                    |  |  |   |   |  |  |
| DUE TO, OR AS A CONSEQUENCE OF (c) <u></u>  |  |                              |  |  |                                    |  |  |   |   |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u></u>   |  |                              |  |  |                                    |  |  |   |   |  |  |
| 19a. DATE OF OPERATION  |  |                              | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |                                    | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>   |  |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |                              | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19   |  |                                    | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |   |   |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK  |  |                              | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  |                                    | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |   |   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>12/22</u> , 19 <u>79</u> , to <u>12/11</u> , 19 <u>79</u> , that (I) (we) last saw the deceased alive on <u>12/11</u> , 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |                              |  |  |                                    |  |  |   |   |  |  |
| 22b. SIGNATURE <u>D. S. Reed MD</u> DEGREE  |  |                              |  |  |                                    | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  |   | 22c. DATE SIGNED <u>12/11/79</u>  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  |                              |  |  |                                    | 22e. ADDRESS   |  |   |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   |  |                              | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY |  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE |   |  |  |
| Burial  |  |                              | 12-5-79  |  | Arbutus Mem.                       |  |  | Baltimore Maryland                      |   |  |  |
| 24. FUNERAL DIRECTOR NAME ADDRESS   |  |                              |  |  |                                    | 25a. DATE REC'D. BY REGISTRAR  |  |   | 25b. REGISTRAR'S SIGNATURE  |  |  |
| Isaiah L. Brown And Son PA 1913 W. Balto. St.   |  |                              |  |  |                                    | DEC 4 1979   |  |   | <u>P. J. H. H. H. H.</u>  |  |  |

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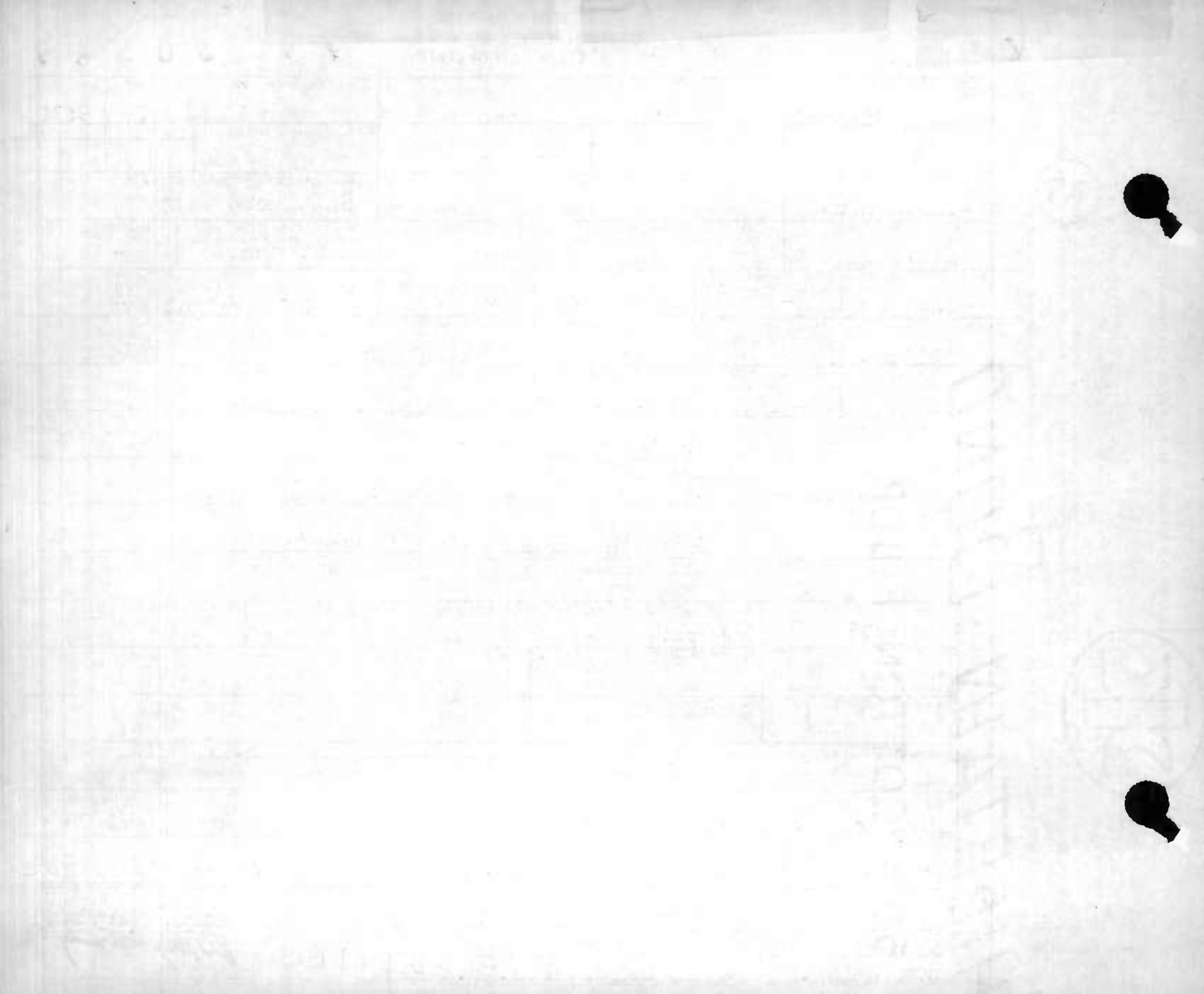
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the registrars, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  |  |  |   |   |  |  | 7 9 3 0 5 4 9<br>REG. NO.  |  |   |  |   |  |   |  |  |  |
|--|--|--|--|--|--|---|---|--|--|--|--|---|--|---|--|---|--|--|--|
| 1. FOR STATE REGISTRAR   |  |  |  |  |  |   |   |  |  | 2a. DATE OF DEATH  |  |   |  | MONTH DAY YEAR                            |  | 2b. HOUR  |  |  |  |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br>Michael J. Reed  |  |  |  |  |  |   |   |  |  | 12 8 79  |  |   |  | 5:30am                                    |  |   |  |  |  |
| 3. SEX<br>M  |  |  | 4. RACE<br>W   |  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>11 19 03  |   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>76 YRS.                                   |  |  | IF UNDER 1 YEAR<br>MONTHS DAYS  |  | IF UNDER 24 HRS.<br>HOURS MIN.            |  |   |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Pennsylvania  |  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  |  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.                   |  |  |   |  |   |  |   |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore   |  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Mercy Hospital |  |  |   |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Maintenance |  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>-  |  |   |  |   |  |  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  |  |  |  |  |   |   |  |  | 13a. STATE<br>Maryland   |  | 13b. COUNTY<br>-  |  | 13c. CITY OR TOWN<br>Baltimore            |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br>5214 Wright Ave |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>William Reed   |  |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Elizabeth Golden              |   |   |  |  |  |  |   |  |   |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>No  |  |  |  |  | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)<br>215-01-8857            |   |   |  |  | 17. INFORMANT ADDRESS<br>Virginia L. Gossman, same address                           |  |   |  |   |  |   |  |  |  |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Probable septic shock<br>436-<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(b) Congestive heart failure & myocardial infarction<br>(c) Bilateral cerebrovascular accidents<br>DUE TO, OR AS A CONSEQUENCE OF<br>DUE TO, OR AS A CONSEQUENCE OF |  |  |  |  |  |   |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |   |  |   |  |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |  |  |  |  |   |   |  |  |  |  |   |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION<br>11/15/79   |  |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br>Suprapubic Foley Insertion |   |   |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |   |  |   |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                     |   |   |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)       |  |   |  |   |  |   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |  |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)            |   |   |  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |  |   |  |   |  |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 12/8/79 to 12/8/79, that (I) (we) lost saw the deceased alive on 12/8/79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |  |  |  |  |   |   |  |  |  |  |   |  |   |  |   |  |  |  |
| 22b. SIGNATURE<br>Stephen Zemel MD   |  |  |  |  |  |   |   |  |  | DEGREE   |  | 22c. DATE SIGNED<br>12/18/79  |  |   |  |   |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Stephen Zemel MD  |  |  |  |  |  |   |   |  |  | 22e. ADDRESS<br>301 St. Paul Pl. Balto. Md. 21202                                    |  |   |  |   |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial  |  |  |  |  | 23b. DATE<br>12/11/79  |   | 23c. NAME OF CEMETERY OR CREMATORY<br>Cedar Hill Cemetery |  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore, Maryland                    |  |   |  |   |  |   |  |  |  |
| 24. FUNERAL DIRECTOR<br>Schimunek Funeral Home, Inc.   |  |  |  |  |  |   |   |  |  | ADDRESS<br>3331 Brehms Lane, Balto. Md. 21213  |  | 25a. DATE REC'D. BY REGISTRAR<br>DEC 11 1979  |  | 25b. REGISTRAR'S SIGNATURE<br>[Signature] |  |   |  |  |  |



DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH7 9 3 0 5 5 0  
REG. NO.1. FOR  
STATE  
REGISTRAR

|  |  |  |  |  |  |   |  |  |  |
|--|--|--|--|--|--|---|--|--|--|
| 1 DECEASED NAME<br>(TYPE OR PRINT) <b>Paul R. Reese</b>  |  |  | 2a DATE OF DEATH<br>MONTH <b>12</b> DAY <b>15</b> YEAR <b>79</b> |  |  | 2b HOUR<br><b>12:20AM</b>   |  |  |  |
| 3 SEX<br><b>Male</b>   |  | 4 RACE<br><b>Black</b>   |  | 5 DATE OF BIRTH<br>MONTH <b>07</b> DAY <b>24</b> YEAR <b>1912</b>  |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br><b>67</b>   |  | 7 IF UNDER 1 YEAR<br>MONTHS <b>00</b> DAYS <b>00</b> HOURS <b>00</b> MIN.  |  |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>South Carolina</b>  |  | 7b CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City Maryland'</b> MD.              |  |  |  |
| 10 CITY OR TOWN OF DEATH<br><b>Baltimore</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>3501 White Chapel Road</b> |  |  |  | 12a USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Administrator</b> |  | 12b KIND OF BUSINESS OR INDUSTRY<br><b>Hospital</b>  |  |
| 13a STATE<br><b>Maryland</b>   |  | 13b COUNTY<br><b>Baltimore</b>   |  | 13d INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 13e STREET ADDRESS<br><b>3501 White Chapel Road</b>                                     |  |  |  |
| 14 FATHER'S NAME<br>FIRST <b>Paul</b> MIDDLE <b>R.</b> LAST <b>Reese Sr.</b>   |  | 15 MOTHER'S MAIDEN NAME<br>FIRST <b>Pauline</b> MIDDLE <b>Hardy</b> LAST <b>Road</b>   |  | 16a WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>NO</b>  |  |   |  |  |  |
| 16b SOCIAL SECURITY NO.<br><b>4029</b>   |  | 16c SOCIAL SECURITY NO.<br><b>323-24-6863</b>  |  | 17 INFORMANT<br>ADDRESS <b>Mrs. Doris H. Reese 3501 White Chape</b>  |  |   |  |  |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cerebrovascular Accident</b><br><b>4029</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(b) <b>Hypertension Cardiovascular Disease</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>7 yrs</b> |  |  |  |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>2 months</b>  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c)   |  |  |  |  |  |   |  |  |  |
| 19a DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>    |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |   |  |  |  |
| 21d INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>Oct 18, 1967</b> to <b>Dec 15, 1979</b> , that (I) (we) last saw the deceased alive on <b>Nov 27, 1979</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |  |  |  |  |   |  |  |  |
| 22b. SIGNATURE<br><b>Roland J. Smoot M.D.</b>  |  | DEGREE   |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                 |  |   |  | 22c. DATE SIGNED<br><b>12/17/79</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Dr. Roland Smoot M.D.</b>  |  | 22e. ADDRESS<br><b>Garwynn Medical Center Balto, Md.</b>   |  |  |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>12-20/79</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Arbutus Cemetery</b>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore MD</b>                       |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Herbert E. Nutter</b>   |  |  |  | ADDRESS<br><b>3035 W. North Ave.</b>   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>DEC 27 1979</b>                                     |  | 25b. REGISTRAR'S SIGNATURE<br><b>notary McCreedy</b>   |  |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

U.S. DEPARTMENT OF THE INTERIOR  
BUREAU OF LAND MANAGEMENT  
WASHINGTON, D.C. 20250

TO: [illegible]  
FROM: [illegible]  
SUBJECT: [illegible]

1. [illegible]  
2. [illegible]  
3. [illegible]

4. [illegible]  
5. [illegible]  
6. [illegible]

7. [illegible]  
8. [illegible]  
9. [illegible]

10. [illegible]  
11. [illegible]  
12. [illegible]

13. [illegible]  
14. [illegible]  
15. [illegible]

16. [illegible]  
17. [illegible]  
18. [illegible]

19. [illegible]  
20. [illegible]  
21. [illegible]

22. [illegible]  
23. [illegible]  
24. [illegible]

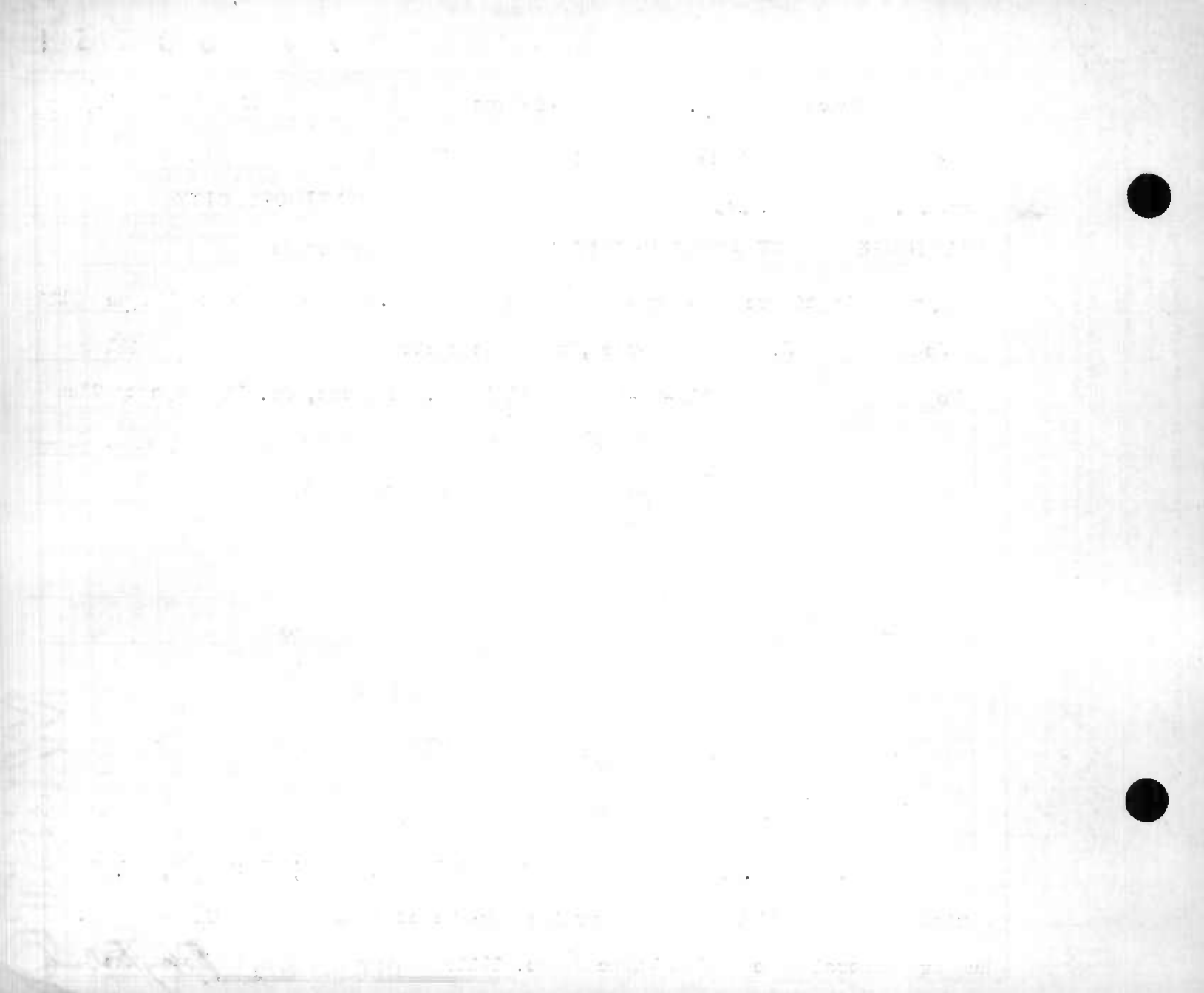


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  |  |  |   |  |                                  |  |                                |  |
|---|--|--|--|--|--|---|--|----------------------------------|--|--------------------------------|--|
| 1. FOR STATE REGISTRAR  |  | 7 9 3 0 5 5 1<br>REG. NO.  |  |  |  |   |  |                                  |  |                                |  |
| 1. DECEASED NAME (TYPE OR PRINT)  |  | FIRST  |  | MIDDLE   |  | LAST  |  | 2a. DATE OF DEATH MONTH DAY YEAR |  | 2b. HOUR                       |  |
| Grace   |  | M.   |  | Reichert   |  |   |  | 12 2 79                          |  | 1:59 a.m.                      |  |
| 3. SEX  |  | 4. RACE  |  | 5. DATE OF BIRTH MONTH DAY YEAR  |  | 6. AGE (IN YEARS LAST BIRTHDAY)   |  | 7. IF UNDER 1 YEAR MONTHS DAYS   |  | 7. IF UNDER 24 HRS. HOURS MIN. |  |
| Female  |  | White  |  | 3 23 31  |  | 48  |  |                                  |  |                                |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH  |  |                                  |  |                                |  |
| Maryland  |  | U.S.A.   |  |  |  | BALTIMORE CITY  |  |                                  |  | MD.                            |  |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |                                  |  |                                |  |
| BALTIMORE   |  | ST AGNES HOSPITAL  |  | Housewife  |  |   |  |                                  |  |                                |  |
| 13a. STATE  |  | 13b. COUNTY  |  | 13c. CITY OR TOWN  |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |  | 13e. STREET ADDRESS              |  |                                |  |
| Maryland  |  |  |  | Baltimore  |  |   |  | 1235 Pine Heights Avenue         |  | 21229                          |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST   |  |  |  |   |  |                                  |  |                                |  |
| John J. Dorsey, Sr.   |  | Henrietta Hill   |  |  |  |   |  |                                  |  |                                |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)   |  | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT  |  | ADDRESS   |  |                                  |  |                                |  |
| No  |  | 212-28-3970  |  | William M. Reichert, Jr.   |  | 367 Majesty Glen  |  |                                  |  |                                |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)   |  | DUE TO, OR AS A CONSEQUENCE OF (b)   |  | DUE TO, OR AS A CONSEQUENCE OF (c)   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |                                  |  |                                |  |
| 410- Acute myocardial infarction  |  | ASCD + Coronary atherosclerosis  |  |  |  | Minutes   |  |                                  |  |                                |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  | now  |  |  |  |   |  |                                  |  |                                |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |                                  |  |                                |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |   |  |                                  |  |                                |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  | 21f. LOCATION CITY OR TOWN COUNTY STATE  |  |   |  |                                  |  |                                |  |
| 22. I certify that (I) (this hospital) attended the deceased from 19 75 to 19 79, that (I) (we) lost saw the deceased alive on 19 79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (do) (did not) view the body after death. |  | 22b. SIGNATURE   |  | DEGREE   |  | 22c. DATE SIGNED  |  |                                  |  |                                |  |
| Earl I. Pass, M.D.  |  | M.D.   |  |  |  | 12/2/79   |  |                                  |  |                                |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  | 22e. ADDRESS   |  |  |  |   |  |                                  |  |                                |  |
| Earl I. Pass, M.D.  |  | 4001 WILKENS AVENUE, BALTIMORE, MD. 21229  |  |  |  |   |  |                                  |  |                                |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE   |  |                                  |  |                                |  |
| Burial  |  | 12/5/79  |  | Lorraine Park  |  | WOODLAWN BALTIMORE MARYLAND   |  |                                  |  |                                |  |
| 24. FUNERAL DIRECTOR NAME   |  | ADDRESS  |  | 25a. DATE REC'D. BY REGISTRAR  |  | 25b. REGISTRAR'S SIGNATURE  |  |                                  |  |                                |  |
| Hubbard Funeral Home  |  | 4107 Wilkens Ave. 21229  |  | DEC 3 1979   |  | Anthony McCreedy  |  |                                  |  |                                |  |



DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

7 9 3 0 5 5 2

REG. NO.

1. FOR  
STATE  
REGISTRAR

|  |  |   |  |   |                                    |  |
|--|--|---|--|---|------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>MARTHA REID</b>   |  |   | 1a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>12/9/79</b>        |   | 2b. HOUR<br><b>6A</b> M            |  |
| 3. SEX<br><b>F</b>   |  | 4. RACE<br><b>B</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>01 13 00</b>   |                                    | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>79</b> YES   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>?</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                    | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>CITY</b> MD.  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTO.</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>SINAI</b> |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>RETIRED</b>  |                                    | 12b. KIND OF BUSINESS OR INDUSTRY  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>MD</b>   |  |   | 13b. COUNTY<br><b>BALTO</b>                                  |   | 13c. CITY OR TOWN<br><b>BALTO.</b> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>JAMES REID</b>  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>ANNA</b> |   |                                    |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>214-40-4731</b>  |  | 17. INFORMANT<br>ADDRESS<br><b>MRS. BETTY S. GRAVES 3713 BARRINGTON RD.</b>   |                                    |  |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardio respiratory Arrest</b><br><b>410-</b> DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>CONGESTIVE HEART FAILURE</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>MICCARDIAL INFARCTION?</b><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |   |  |   |                                    |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><b>OLD @ CVA - Aspiration Pneumonia</b>   |  |   |  |   |                                    |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                                    | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |                                    |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |                                    |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>12/6</b> , 19 <b>79</b> , to <b>12/9</b> , 19 <b>79</b> , that (I) (we) last saw the deceased alive on <b>12/4</b> , 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.         |  |   |  |   |                                    |  |
| 22b. SIGNATURE<br><b>[Signature]</b>   |  | DEGREE<br><b>MD</b>   |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>                  |                                    | 22c. DATE SIGNED<br><b>12/9/79</b>   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Nilvio R. Aguirre</b>  |  | 22e. ADDRESS<br><b>Sinai Hospital</b>   |  |   |                                    |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>BURIAL</b>   |  | 23b. DATE<br><b>12-12-79</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>ARBUTUS MEMORIAL PARK</b>  |                                    | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>BALTIMORE, MD.</b>  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>LEROY O. DYETT &amp; SON, INC.</b>  |  |   |  | ADDRESS<br><b>4600 Lib. Hghts. Av.</b>  |                                    | 25a. DATE REC'D. BY REGISTRAR<br><b>DEC 11 1979</b>  |
|  |  |   |  | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>  |                                    |  |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 of 2.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

2000-1-1

1. The first part of the paper is devoted to a general discussion of the problem. It is shown that the problem is of great importance and that it has not been completely solved. The author then proceeds to a detailed analysis of the problem, showing that it is a special case of a more general problem. The author then discusses the various methods that have been used to solve the problem, and shows that the method proposed in this paper is the most efficient.

2. In the second part of the paper, the author discusses the various methods that have been used to solve the problem. It is shown that the method proposed in this paper is the most efficient. The author then discusses the various methods that have been used to solve the problem, and shows that the method proposed in this paper is the most efficient.

3. In the third part of the paper, the author discusses the various methods that have been used to solve the problem. It is shown that the method proposed in this paper is the most efficient. The author then discusses the various methods that have been used to solve the problem, and shows that the method proposed in this paper is the most efficient.

TO HOSPITAL: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death. TO FUNERAL DIRECTOR: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH-16 25M  
(VRA 15, 4) 1/79

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  |  |  |  |  |   |  |
|--|--|--|--|--|--|--|--|---|--|
| 1. FOR STATE REGISTRAR   |  | 7. REG. NO. 30553  |  | 7. REG. NO. 30553  |  | 7. REG. NO. 30553  |  | 7. REG. NO. 30553   |  |
| 1. DECEASED NAME (TYPE OR PRINT) <b>LOUIS JOSEPH REULING, Jr.</b>  |  |  |  | 2a. DATE OF DEATH MONTH <b>12</b> DAY <b>15</b> YEAR <b>79</b>   |  | 2b. HOUR <b>930</b> AM   |  |   |  |
| 3. SEX <b>Male</b>   |  | 4. RACE <b>White</b>   |  | 5. DATE OF BIRTH MONTH <b>9</b> DAY <b>7</b> YEAR <b>17</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY) <b>62</b> YRS.   |  | 6. AGE (IN YEARS LAST BIRTHDAY) <b>62</b> YRS.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MARYLAND</b>  |  | 7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY</b> MD.                                 |  |   |  |
| 10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>ST. AGNES HOSPITAL</b> |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Salesman - Imp. Packaging</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY <b>Retail Paper Supply</b>  |  |
| 13a. STATE <b>Md.</b>  |  | 13b. COUNTY <b>Baltimore</b>   |  | 13c. CITY OR TOWN <b>Catonsville</b>   |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 13e. STREET ADDRESS <b>2107 Edmondson Avenue</b>  |  |
| 14. FATHER'S NAME FIRST <b>Louis</b> MIDDLE <b>J.</b> LAST <b>Reuling, Sr.</b>   |  |  |  | 15. MOTHER'S MAIDEN NAME FIRST <b>Elizabeth</b> MIDDLE <b>Hackman</b> LAST <b>Hackman</b>  |  |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>  |  |  |  | 16b. SOCIAL SECURITY NO. <b>212-07-9829</b>  |  | 17. INFORMANT <b>Catonsville, Md. 21228</b><br><b>Mrs. Vivian M. Reuling-2107 Edmondson</b>    |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1: DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CARCINOMA OF PANCREAS WITH METASTASES</b><br><b>1579</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |  |  |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1</b> Year  |  |
| PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>DIABETES MELLITUS &amp; ATHERO SCLEROTIC CARDIO VASC. DIS.</b>  |  |  |  |  |  |  |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>              |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |  |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>12/14</b> 19 <b>79</b> , to <b>12/15</b> 19 <b>79</b> , that (I) (we) last saw the deceased alive on <b>12/15</b> 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                              |  |  |  |  |  |  |  |   |  |
| 22b. SIGNATURE <b>C. D'Arcy</b>  |  |  |  | DEGREE <b>ATTENDING PHYSICIAN</b> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>                          |  |  |  | 22c. DATE SIGNED <b>12/15/79</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>CATHERINE D'ARCANGUES</b>   |  |  |  | 22e. ADDRESS <b>900 CATON AVE. BALTIMORE, MD. 21229</b>  |  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>  |  | 23b. DATE <b>12/19/79</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY <b>Lake View Mem. Park Sykesville, Maryland</b>   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE  |  |   |  |
| 24. FUNERAL DIRECTOR NAME <b>Stirling Funeral Estate</b>   |  |  |  | 24. FUNERAL DIRECTOR ADDRESS <b>736 Edmondson Ave. Baltimore, Md. 21229</b>  |  |  |  | 25. DATE REC'D. BY REGISTRAR <b>DEC 19 1979</b>   |  |

BP



BALTIMORE CITY

ST. JAMES HOSPITAL

BALTIMORE

Mr. William C. ...

J. ...

Louis

...

CARDIAC ...

DIABETES ...

...

Items #18a-22a Film G540 2/8/80 re STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH 9 REG. NO. 3 0 5 5 4

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST  
ALFRED RICH

2a. DATE OF DEATH KNOWN ☐ ESTIMATED ☒ MONTH DAY YEAR  
12 29 1979

2b. HOUR  
M

3. SEX  
male

4. RACE  
negro

5. DATE OF BIRTH MONTH DAY YEAR  
Mar 21, 1929

6. AGE (IN YEARS) LAST BIRTHDAY  
50 YRS

IF UNDER 1 YR. MONTHS DAYS HOURS MIN.

IF UNDER 24 HRS.

7c. DATE PRONOUNCED DEAD MONTH DAY YEAR  
12 29 1979

7d. HOUR  
7:41 a M

7e. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  
Maryland

7f. CITIZEN OF WHAT COUNTRY?  
USA

8. MARRIED ☒ NEVER MARRIED ☐  
WIDOWED ☐ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH  
Baltimore City MD

10. CITY OR TOWN OF DEATH  
Baltimore

11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)  
224 N. Carlton Ave.

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  
Laborer

12b. KIND OF BUSINESS OR INDUSTRY

13a. STATE  
Maryland

13b. COUNTY  
-----

13c. CITY OR TOWN  
Baltimore

13d. INSIDE CITY LIMITS? YES ☒ NO ☐

13e. STREET ADDRESS  
1052 W. Saratoga Street

14. FATHER'S NAME FIRST MIDDLE LAST  
Eldridge Rich

15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST  
Laura Williams

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)  
Yes

16b. SOCIAL SECURITY NO.  
WW II 219140848 A

17. INFORMANT ADDRESS  
Mrs. E. Rich 1052 W. Saratoga St.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART 1 DEATH WAS CAUSED BY:  
4243 IMMEDIATE CAUSE (a) Chronic obstructive pulmonary disease  
DUE TO, OR AS A CONSEQUENCE OF  
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last:  
(b) \_\_\_\_\_  
DUE TO, OR AS A CONSEQUENCE OF  
(c) \_\_\_\_\_  
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?

20. AUTOPSY? YES ☒ NO ☐

21a. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH

21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR  
P.M. 19

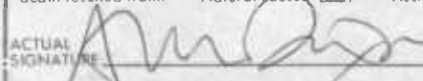
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

21d. INJURY OCCURRED WHILE ☐ NOT WHILE ☐ AT WORK ☐ AT WORK

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)

21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☐, Inquiry ☐, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐.

ACTUAL SIGNATURE  TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER DATE SIGNED 12-29-79

EXAMINER'S NAME (TYPE OR PRINT) Ann M. Dixon, M.D. ADDRESS 111 Penn St.

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  
Burial

23b. DATE  
2 Jan 80

23c. NAME OF CEMETERY OR CREMATORY  
Mt. Auburn Cem.

23d. LOCATION CITY OR TOWN COUNTY STATE  
Baltimore Maryland

24. FUNERAL DIRECTOR NAME  
Powell F/H

25a. DATE REC'D. BY REGISTRAR  
JAN 4 1980

25b. ADDRESS  
319 N. Schroeder Street

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 3 TO YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN FOUR HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.



RECEIVED  
JAN 1 1950

100-100000

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  |   |  |   |  |  |  | 79 30555  |  |
|--|--|---|--|---|--|---|--|--|--|---|--|
| FOR<br>STATE<br>REGISTRAR  |  | REG. NO.  |  |   |  |   |  |  |  |   |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>JACOB P. RINGGER</b>  |  |   |  |   | 2a. DATE OF DEATH<br>MONTH <b>12</b> DAY <b>2</b> YEAR <b>79</b> |   |  | 2b. HOUR<br><b>6 45</b> A.M.   |  |   |  |
| 3. SEX<br><b>MALE</b>  |  | 4. RACE<br><b>WHITE</b>   |  | 5. DATE OF BIRTH<br>MONTH <b>3</b> DAY <b>09</b> YEAR <b>1886</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>93</b> YRS. MONTHS <b>03</b> DAYS <b>00</b>               |  | 7. IF UNDER 1 YEAR<br>MONTHS <b>03</b> DAYS <b>00</b>  |  | 7b. IF UNDER 24 HRS<br>HOURS <b>45</b> MIN. <b>00</b> |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland S.A.</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY, MD.</b>                              |  |  |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>GOOD SAMARITAN HOSPITAL</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Pottawone</b>            |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>China Co.</b>  |  |   |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br><b>MARYLAND</b>  |  | 13b. COUNTY<br><b>-</b>   |  | 13c. CITY OR TOWN<br><b>BALTIMORE</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS <b>5807 FALKIRK RD.</b><br><b>21239</b>  |  |   |  |
| 14. FATHER'S NAME<br>FIRST <b>RUDOLPH</b> MIDDLE <b>RINGGER</b> LAST <b>RINGGER</b>  |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>ANNA</b> MIDDLE <b>WINTERLING</b> LAST <b>WINTERLING</b>   |  |   |  |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>no</b>  |  |   |  | 16b. SOCIAL SECURITY NO.<br><b>212-26-7142</b>  |  | 17. INFORMANT<br>ADDRESS<br><b>Mary A. Ringger 5807 Falkirk Rd. 21239</b>                       |  |  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CARDIORESPIRATORY ARREST</b><br><b>5325</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>PUMP FAILURE</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>SEVERE CONGESTIVE HEARTFAILURE</b>   |  |   |  |   |  |   |  |  |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH       |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):<br><b>PERFORATED DUODENAL ULCER WITH SEPSIS, COPD</b>   |  |   |  |   |  |   |  |  |  |   |  |
| 19a. DATE OF OPERATION<br><b>11-25-1979</b>  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>PERFORATED DUODENAL ULCER</b>  |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>              |  |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |  |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET<br><b>CITY OR TOWN</b><br><b>COUNTY</b><br><b>STATE</b>   |  |   |  |  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>11-25-</b> 19 <b>79</b> to <b>12-2-</b> 19 <b>79</b> , that (I) (we) lost<br>saw the deceased alive on <b>12-2-</b> 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death. |  |   |  |   |  |   |  |  |  |   |  |
| 22b. SIGNATURE<br><b>John Kurian</b>   |  |   |  | DEGREE<br><b>MD</b>   |  |   |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br><b>12-2-1979</b>                  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>GEORGE KURIAN</b>  |  |   |  | 22e. ADDRESS<br><b>GOOD SAMARITAN HOSPITAL BALTO. 21239</b>   |  |   |  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>Dec. 5, 1980</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Sacred Heart Jesus Cem</b>   |  | 23d. LOCATION<br>CITY OR TOWN<br><b>Baltimore Co.,</b>  |  | COUNTY<br><b>Md.</b>   |  | STATE   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Dippel Brothers, Inc.</b>   |  |   |  | ADDRESS<br><b>7110 Belair Rd. 21206</b>   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>DEC 3 1979</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>History</b>   |  |   |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 3 and 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 50M 1/76  
(VR A 15 (4))

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

7 9 3 0 5 5 6

1- FOR  
STATE  
REGISTRAR

|  |  |   |   |  |
|--|--|---|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><del>XXXXXXXXXX</del> Aimee E. Ringrose <del>XXXXXX</del>   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>Dec 20 79  |   | 2b. HOUR<br>7:35 A.M.  |
| 3. SEX<br>Female   | 4. RACE<br>White   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>March 27 1905   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>74 YRS  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>MD  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD.                                      |  |
| 10. CITY OR TOWN OF DEATH<br>BALTO.  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Mercy Hosp., ST PAUL ST BALTO |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>XXXXXXXXXX at home          | 12b. KIND OF BUSINESS OR INDUSTRY  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  |   |   |  |
| 13a. STATE<br>MD   | 13b. COUNTY<br>XXXXXX  | 13c. CITY OR TOWN<br>BALTO  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS<br>4353 SHAMROCK AVE   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>George W. LaFlame  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Nettie Anderson  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>NO   |  | 16b. SOCIAL SECURITY NO.<br>219-16-5849   |   | 17. INFORMANT<br>Mr. Paul Ringrose same  |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) 586- ELECTROLYTE IMBALANCE OR RESP. FAILURE<br>DUE TO, OR AS A CONSEQUENCE OF (b) RENAL FAILURE<br>DUE TO, OR AS A CONSEQUENCE OF (c) OR POSSIBLE ASPIRATION OF GULM EMBOLI |  |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |   |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  |   |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   |  |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  | 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |   |  |
| 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 10/18/79 to 12/20/79, that (I) (we) last saw the deceased alive on 12/20/79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.   |  |   |   |  |
| 22b. SIGNATURE<br>Edw. J. Doolin   |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>        |   | 22c. DATE SIGNED<br>12/20/79   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>E J Doolin  |  | 22e. ADDRESS<br>Mercy Hosp ST PAUL ST BALTO MD  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial  | 23b. DATE<br>Dec. 22, 1979   | 23c. NAME OF CEMETERY OR CREMATORY<br>Most Holy Redeemer  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore, Md.                                    |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Leonard J. Ruck Inc. Baltimore, Md.  |  | 25a. DATE REC'D. BY REGISTRAR<br>DEC 21 1979  |   | 25b. REGISTRAR'S SIGNATURE<br>Rickey K. Brady  |

MEDICAL CERTIFICATION

1894

20

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

7 9 3 0 5 5 7  
REG. NO.

1. FOR  
STATE  
REGISTRAR

|  |  |   |  |   |  |  |   |   |   |  |
|--|--|---|--|---|--|--|---|---|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Elizabeth T. Ritchie  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>Dec 14, 1979                      |   |  | 2b. HOUR<br>11A M  |   |   |   |  |
| 3 SEX<br>Female  |  | 4 RACE<br>White   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>Aug, 10 1904  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>75 YRS.   |   | 7. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN   |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Md  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD.                           |   |   |   |  |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Hopkins Apts |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>ARTIST           |   | 12b. KIND OF BUSINESS OR INDUSTRY   |   |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>Md  |  |   | 13b. COUNTY<br>BALTIMORE   |   | 13c. CITY OR TOWN<br>BALTIMORE   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   | 13e. STREET ADDRESS<br>ST. PAUL 731st ST. |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>DAVID DUTROW THOMAS SR   |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>MARY Elizabeth Williams |   |  |  |   |   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>NO   |  |   | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>220-05-3444   |   | 17. INFORMANT<br>DAVID D. THOMAS JR  |  | ADDRESS<br>228 E. Padonia Rd.   |   |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) acute myocardial infarction<br>410-<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) Hypertensive cerebrovascular disease<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>Sudden 17yr |  |   |  |   |  |  |   |   |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)<br>secretory mucus   |  |   |  |   |  |  |   |   |   |  |
| 19a. DATE OF OPERATION   |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                         |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19               |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) |  |   |   |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |  |   |   |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 12/13/79 to 12/14/79, that (I) (we) last saw the deceased alive on 12/13/79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |   |  |   |  |  |   |   |   |  |
| 22b. SIGNATURE<br>Wm. F. Penner MD   |  |   | DEGREE<br>MD   |   |  | 22c. DATE SIGNED<br>12/14/79   |   |   |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Wm. F. Penner   |  |   | 22e. ADDRESS<br>3222 St. Paul St   |   |  |  |   |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>BURIAL  |  |   | 23b. DATE<br>DEC. 17, 1979   |   | 23c. NAME OF CEMETERY OR CREMATORY<br>DRUID RIDGE                              |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Pikesville BALTO Md.                              |   |   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Mitchell-Widefeld Home   |  |   | ADDRESS<br>6500 YORK RD  |   |  | 25a. DATE REC'D. BY REGISTRAR<br>DEC 18 1979   |   | 25b. REGISTRAR'S SIGNATURE<br>Marilyn McCurdy   |   |  |



RELEASED AS ON APPROVAL BY DR KORELL OFFICE MEDICAL  
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical Examiner must be notified at once.

DHMH-16 25M  
(VRA 15, 4) 1/79

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

7 9 3 0 5 5 8  
REG. NO.

FOR  
STATE  
REGISTRAR

|   |  |   |        |   |                    |                                   |                    |      |            |
|---|--|---|--------|---|--------------------|-----------------------------------|--------------------|------|------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |  | FIRST   | MIDDLE | LAST  | 2a. DATE OF DEATH  | MONTH                             | DAY                | YEAR | 2b. HOUR   |
| ELIZABETH ROSE ROBERTSON  |  |   |        |   | DECEMBER 12, 1979  |                                   |                    |      | 04:28 PM   |
| 3. SEX  | 4. RACE  | 5. DATE OF BIRTH  |        | 6. AGE (IN YEARS LAST BIRTHDAY)                                     | 7. IF UNDER 1 YEAR |                                   | 8. IF UNDER 24 HRS |      |            |
| Female  | Caucasian  | MONTH Jan. 28, 1914   |        | 65  | MONTHS             |                                   | DAYS               |      | HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   | 7b. CITIZEN OF WHAT COUNTRY?   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |        | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |                    |                                   |                    |      |            |
| Maryland  | U.S.A.   |   |        | BALTIMORE CITY MD.  |                    |                                   |                    |      |            |
| 10. CITY OR TOWN OF DEATH   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE RESIDENCE ADDRESS) |   |        | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)    |                    | 12b. KIND OF BUSINESS OR INDUSTRY |                    |      |            |
| Baltimore City  | THE JOHNS HOPKINS HOSPITAL   |   |        | Ret. Seamstress   |                    | None                              |                    |      |            |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) |  |   |        |   |                    |                                   |                    |      |            |
| 13a. STATE  | 13b. COUNTY  | 13c. CITY OR TOWN   |        | 13d. INSIDE CITY LIMITS?  |                    | 13e. STREET ADDRESS               |                    |      |            |
| Maryland  | Frederick  | Thurmont  |        | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                    | 507 East Main Street              |                    |      |            |
| 14. FATHER'S NAME   |  | 15. MOTHER'S MAIDEN NAME  |        | ADDRESS   |                    |                                   |                    |      |            |
| FIRST MIDDLE LAST   |  | FIRST MIDDLE LAST   |        | 507 E. Main Street  |                    |                                   |                    |      |            |
| Clem H. Reckley   |  | Flossie M. House  |        | Mr. Charles V. Robertson Thurmont, Md. 21788                        |                    |                                   |                    |      |            |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)                    |  | 16b. SOCIAL SECURITY NO.  |        | 17. INFORMANT   |                    |                                   |                    |      |            |
| No  |  | XXXXXXX   |        | 177-26-6899   |                    |                                   |                    |      |            |

|  |  |  |  |   |  |
|--|--|--|--|---|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |  |  |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH   |  |
| PART 1 DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) HEART FAILURE   |  |  |  |   |  |
| 3949 DUE TO, OR AS A CONSEQUENCE OF  |  |  |  | MITRAL VALVE REGURGITANT  |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.   |  |  |  | (b) <del>DEEP CORONARY ARTERY BYPASS</del> (c) VENTRICULAR ANEURYSM   |  |
| DUE TO, OR AS A CONSEQUENCE OF   |  |  |  | (c) CORONARY ARTERY DISEASE, (d) VENTRICULAR ANEURYSM, MITRAL VALVE DYSPLASIA   |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):  |  |  |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  | 20a. AUTOPSY?   |  |
| 12/12/79   |  | HEART FAILURE  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR                        |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |
|  |  | P.M. 19  |  | No Injury   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |
|  |  | 601 N. Broadway  |  | BALTIMORE MD.   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |   |  |
| 22b. SIGNATURE   |  | DEGREE   |  | 22c. DATE SIGNED  |  |
| Ralph Keane  |  | M.D., B.C.   |  | 12/12/79  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  | 22e. ADDRESS   |  | 22f. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  |
| RALPH KEANE  |  | 601 N. Broadway  |  | BALTIMORE, MD.  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)   |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY  |  |
| Burial   |  | 12-15-1979   |  | Resthaven Mem. Gardens  |  |
| 23d. FUNERAL DIRECTOR<br>NAME  |  | 23e. ADDRESS   |  | 23f. LOCATION<br>CITY OR TOWN COUNTY STATE  |  |
| Robert E. Dailey & Son   |  | 615 East Main Street<br>Thurmont, Md. 21788                            |  | Frederick, Frederick Md.  |  |
| 24. DATE REC'D. BY REGISTRAR   |  | 25. REGISTRAR'S SIGNATURE  |  | 26. REGISTRAR'S SIGNATURE   |  |
| DEC 18 1979  |  |  |  |   |  |



RECEIVED AT THE OFFICE OF THE DIRECTOR

RECEIVED AT THE OFFICE OF THE DIRECTOR

12/15/50  
12/15/50  
12/15/50

12/15/50  
12/15/50  
12/15/50



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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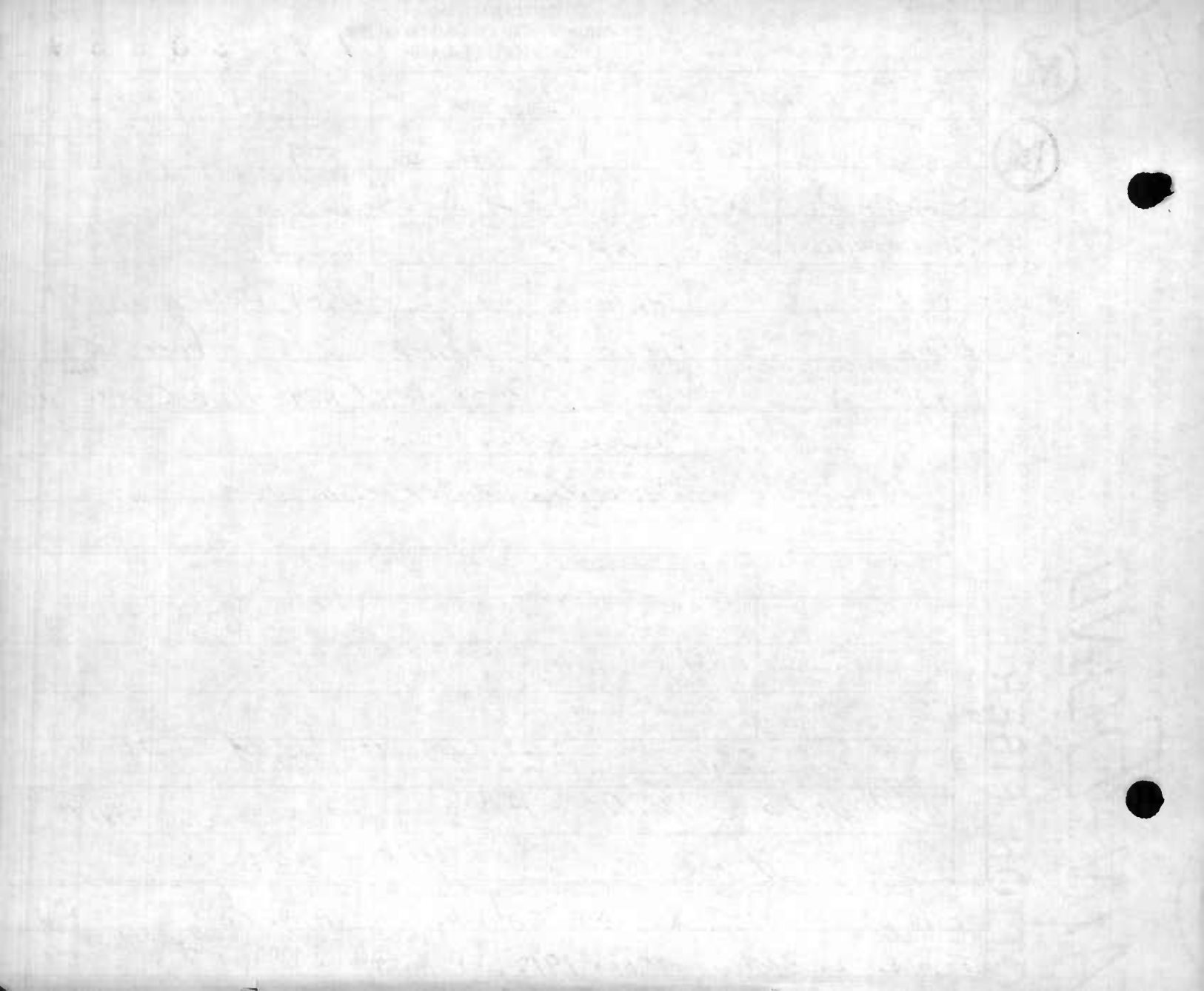
STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1930559

FOR  
STATE  
REGISTRAR

|  |  |   |  |  |  |  |  |   |  |
|--|--|---|--|--|--|--|--|---|--|
| 1 DECEASED NAME<br>(TYPE OR PRINT)<br><b>ANNA</b>  |  | FIRST<br><b>ROBINSON</b>  |  | LAST   |  | 2a DATE OF DEATH<br>MONTH DAY YEAR<br><b>12 31 79</b>  |  | 2b HOUR<br><b>5:20 PM</b>   |  |
| 3 SEX<br><b>F</b>  |  | 4 RACE<br><b>Black</b>  |  | 5 DATE OF BIRTH<br>MONTH DAY YEAR<br><b>8 16 20</b>  |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br><b>59</b> YRS  |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN<br><b>59</b>   |  |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MARYLAND</b>  |  | 7b CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.                               |  |   |  |
| 10 CITY OR TOWN OF DEATH<br><b>Baltimore, MD</b>   |  | 11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Sinai Hospital</b> |  |  |  | 12a USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Domestic</b>             |  | 12b KIND OF BUSINESS OR INDUSTRY  |  |
| 13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a STATE<br><b>MD</b>  |  | 13b COUNTY  |  | 13c CITY OR TOWN<br><b>BALTO</b>   |  | 13d INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e STREET ADDRESS<br><b>4601 PALL Mall Rd.</b>   |  |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Elma</b>   |  | 15 MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>ANITA</b>  |  | 16a WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>   |  | 16b SOCIAL SECURITY NO.  |  | 17 INFORMANT<br><b>Debra McCARGO</b>  |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiopulmonary arrest</b><br><b>4275</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(b) <b>Encephalopathy 20 Cardiac arrest</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Cardiac arrest</b> |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |  |  |  |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |   |  |  |  |  |  |   |  |
| 19a DATE OF OPERATION  |  | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  |  | 20a AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                       |  | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  |  | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |   |  |
| 21d INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |   |  |
| 22a I certify that (I) (this hospital) attended the deceased from <b>12/28</b> , 19 <b>77</b> , to <b>12/31</b> , 19 <b>77</b> , that (I) (we) last saw the deceased alive on <b>12/31</b> , 19 <b>77</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) (did) (did not) view the body after death.                       |  |   |  |  |  |  |  |   |  |
| 22b SIGNATURE<br><b>J. M. Starn</b> MD   |  | DEGREE<br><b>MD</b>   |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>                 |  |  |  | 22c DATE SIGNED<br><b>12/31/79</b>  |  |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Jay M Starn</b>   |  | 22e ADDRESS<br><b>SINAI Hospital</b>  |  |  |  |  |  |   |  |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>BURIAL</b>  |  | 23b DATE<br><b>1-3-80</b>   |  | 23c NAME OF CEMETERY OR CREMATORY<br><b>MT CALVARY Cem</b>   |  | 23d LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>BALTO MD</b>                                   |  |   |  |
| 24 FUNERAL DIRECTOR<br>NAME<br><b>ISAIAH L. BROWN &amp; SON</b>  |  | ADDRESS<br><b>1913 W. BALTO ST</b>  |  | 25a DATE REC'D. BY REGISTRAR<br><b>3 1980</b>  |  | 25b REGISTRAR'S SIGNATURE<br><b>Anthony M. Cuddy</b>   |  |   |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  |  |   |                                      |   |                 |   | REG. NO. 79 30560 |                     |  |
|--|--|--|--|--|---|--------------------------------------|---|-----------------|---|-------------------|---------------------|--|
| 1. FOR STATE REGISTRAR   |  |  |  |  | 2a. DATE OF DEATH   |                                      | MONTH DAY YEAR  |                 | 7b. HOUR  |                   |                     |  |
| 1. DECEASED NAME (TYPE OR PRINT) <u>LAWRENCE ROBINSON</u>  |  |  |  |  | 2a. DATE OF DEATH   |                                      | MONTH DAY YEAR  |                 | 7b. HOUR  |                   |                     |  |
| 3. SEX   |  | 4. RACE  |  | 5. DATE OF BIRTH   |   | 6. AGE (IN YEARS LAST BIRTHDAY)      |   | 7. UNDER 1 YEAR |   | 8. UNDER 24 HRS.  |                     |  |
| MALE   |  | BLACK  |  | 8-12-1917  |   | 62 YRS.                              |   | MONTHS DAYS     |   | HOURS MIN.        |                     |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH |   |                 |   |                   |                     |  |
| MARYLAND   |  | USA  |  |  |   | BALTIMORE CITY MD.                   |   |                 |   |                   |                     |  |
| 10. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |   | 12b. KIND OF BUSINESS OR INDUSTRY    |   |                 |   |                   |                     |  |
| BALTIMORE  |  | SBG HOSPITAL   |  | STEEL WORKER   |   | STEEL                                |   |                 |   |                   |                     |  |
| 13a. STATE   |  |  |  |  | 13b. COUNTY   |                                      | 13c. CITY OR TOWN   |                 | 13d. INSIDE CITY LIMITS?  |                   | 13e. STREET ADDRESS |  |
| MD   |  |  |  |  | BALT. CITY  |                                      | BALTIMORE   |                 | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                   | 629 HILLVIEW RD     |  |
| 14. FATHER'S NAME  |  |  |  |  | 15. MOTHER'S MAIDEN NAME  |                                      |   |                 |   |                   |                     |  |
| FIRST MIDDLE LAST  |  |  |  |  | FIRST MIDDLE LAST   |                                      |   |                 |   |                   |                     |  |
| NOT KNOWN  |  |  |  |  | MARY (NOT KNOWN)  |                                      |   |                 |   |                   |                     |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)  |  |  |  |  | 16b. SOCIAL SECURITY NO.  |                                      | 17. INFORMANT   |                 | ADDRESS   |                   |                     |  |
| YES  |  |  |  |  | ARMY  |                                      | WIFE  |                 | 629 HILLVIEW RD   |                   |                     |  |
| 21. INJURY OCCURRED  |  |  |  |  | 21a. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |                                      | 21b. LOCATION   |                 | CITY OR TOWN  |                   | COUNTY STATE        |  |
| WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |  |  |  |   |                                      |   |                 |   |                   |                     |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 1:20p 12/1, 1979, to 1:50p 12/1, 1979, that (I) (we) lost |  |  |  |  | 22b. DATE SIGNED  |                                      |   |                 |   |                   |                     |  |
| 22c. SIGNATURE   |  |  |  |  | DEGREE  |                                      | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |                 |   |                   |                     |  |
| 22d. SIGNATURE (FAN'S NAME) (TYPE OF PRINT)  |  |  |  |  | 22e. ADDRESS  |                                      |   |                 |   |                   |                     |  |
| 22f. SIGNATURE   |  |  |  |  | 22g. ADDRESS  |                                      |   |                 |   |                   |                     |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |  |  |  |  | 23b. DATE   |                                      | 23c. NAME OF CEMETERY OR CREMATORY  |                 | 23d. LOCATION CITY OR TOWN  |                   | COUNTY STATE        |  |
| Burial   |  |  |  |  | 12/6/1979   |                                      | Cedar Hill Cemetery   |                 | Anne Arundel Co., Maryland  |                   |                     |  |
| 24. FUNERAL DIRECTOR   |  |  |  |  | 25a. DATE REC'D. BY REGISTRAR                                       |                                      | 25b. REGISTRAR'S SIGNATURE  |                 |   |                   |                     |  |
| William C. March   |  |  |  |  | DEC 3 1979  |                                      | Ruthy McBrady   |                 |   |                   |                     |  |



Handwritten signature or initials in the bottom left corner.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

Item 8g539 1/18/80 g3

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

1- FOR STATE REGISTRAR

REG. NO. 7930561

|   |  |  |  |   |  |
|---|--|--|--|---|--|
| 1 DECEASED NAME (TYPE OR PRINT)<br>MARIE ROBINSON   |  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br>12 20 79                             |   | 2b. HOUR<br>805 PM   |
| 3 SEX<br>Female   | 4. RACE<br>Black   | 5. DATE OF BIRTH MONTH DAY YEAR<br>03 01 011   |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br>68  | IF UNDER 1 YEAR MONTHS DAYS<br>9 19  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.                                       |  |
| 10 CITY OR TOWN OF DEATH<br>Baltimore City  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>UNIVERSITY OF MARYLAND HOSP. |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Retired |   | 12b. KIND OF BUSINESS OR INDUSTRY  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>Maryland   |  | 13b. COUNTY<br>BALTIMORE   | 13c. CITY OR TOWN<br>BALTIMORE   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS<br>1802 S. EAGLE STREET 21223  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>Willie Agnew   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Carrie   |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>No                         |  |
| 16b. SOCIAL SECURITY NO.<br>247-28-4358   |  | 17. INFORMANT ADDRESS<br>REGISTRATION RECORD   |  |   |  |
| 18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Renal Failure<br>585-<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |  |  |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br>Chronic + Acute Renal Failure, Cholelithiasis, DIC, Hepatic Failure, Sick Sinus Syndrome   |  |  |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>            | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                  |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from Dec. 13 19 79, to Dec. 20 19 79, that (I) (we) last saw the deceased alive on Dec. 20 19 79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.                            |  |  |  |   |  |
| 22b. SIGNATURE<br>Dr. Marlene Jaro  |  |  | DEGREE<br>M.D.   |   | 22c. DATE SIGNED<br>12/20/79   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>DR. MARLENE JARO   |  |  | 22e. ADDRESS<br>3 Sulky Ct. #202 RANDALLSTOWN, MD. 21133                 |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial   |  | 23b. DATE<br>12/27/79  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Baltimore Cemetery  |  |
| 23d. LOCATION (SPECIFY)<br>Baltimore, Maryland  |  | 23e. NAME OF CEMETERY OR CREMATORY<br>Baltimore, Maryland  |  |   |  |
| 24 FUNERAL DIRECTOR'S NAME<br>KENNETH LAW FUNERAL HOME  |  | 24b. ADDRESS<br>4611 Park Hgts Ave.  |  | 25a. DATE REC'D. BY REGISTRAR<br>JAN 3 1980   |  |
| 25b. REGISTRAR'S SIGNATURE<br>R. J. J. J.   |  | 25c. REGISTRAR'S SIGNATURE   |  |   |  |

Serial

12/27/70 Affiliates of Gregory, William, and Maryland

1120 E. 1st Ave.

100-100000-247-20-4351

Garrig

Willie Brown

Retired



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE  
EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING," IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR.  
PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR THE  
TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITH THE  
AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W.  
BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |         |  |  |   |  |   |  |   |  | REG. NO. 30562  |  |
|--|---------|--|--|---|--|---|--|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |         | FIRST  |  | MIDDLE  |  | LAST  |  | 2a. DATE KNOWN<br>OF DEATH  |  | 2b. HOUR  |  |
| DOROTHY  |         | L.   |  | ROLBIN  |  |   |  | ESTIMATED <input checked="" type="checkbox"/> 12 28 1979                      |  | M   |  |
| 3. SEX   | 4. RACE | 5. DATE OF BIRTH   |  | 6. AGE (IN YEARS)   |  | IF UNDER 1 YR.  |  | IF UNDER 24 HRS.  |  | 2c. DATE<br>PRONOUNCED<br>DEAD                                      |  |
| female   | white   | 5 23 1920  |  | 59 YRS.   |  |   |  |   |  | 12 29 1979  |  |
| 7a. BIRTHPLACE (STATE OR<br>FOREIGN COUNTRY)   |         | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |  |   |  | 10. HOUR  |  |
| Maryland   |         | U.S.A.   |  |   |  | Baltimore City  |  |   |  | 10:25 a M   |  |
| 10. CITY OR TOWN OF DEATH  |         | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 12a. USUAL OCCUPATION (TYPE OF WORK<br>FOR MOST OF WORKING LIFE)  |  | 12b. KIND OF BUSINESS<br>OR INDUSTRY                                |  |   |  |   |  |
| Baltimore  |         | 200 S. Gilmore St.   |  | Housewife   |  |   |  |   |  |   |  |
| 13a. STATE   |         | 13b. COUNTY  |  | 13c. CITY OR TOWN   |  | 13d. INSIDE CITY LIMITS?  |  | 13e. STREET ADDRESS   |  |   |  |
| Maryland   |         |  |  | Baltimore   |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 200 S. Gilmore Street   |  |   |  |
| 14. FATHER'S NAME  |         | 15. MOTHER'S MAIDEN NAME   |  | 16. SOCIAL SECURITY NO.   |  | 17. INFORMANT   |  | ADDRESS   |  |   |  |
| FIRST MIDDLE LAST  |         | FIRST MIDDLE LAST  |  |   |  |   |  |   |  |   |  |
| Frederick  |         | Dora   |  | 214-14-2008   |  | Marie A. Watts -  |  | 3203 Grace Rd.  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)  |         | (IF YES, GIVE WAR OR DATES)  |  |   |  |   |  | Balto. MD 21219   |  |   |  |
| No   |         |  |  |   |  |   |  |   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:   |         |  |  |   |  |   |  |   |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH                     |  |
| IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease  |         |  |  |   |  |   |  |   |  |   |  |
| 43922 } DUE TO, OR AS A CONSEQUENCE OF   |         |  |  |   |  |   |  |   |  |   |  |
| Conditions, if any, which<br>gave rise to immediate<br>cause (a) stating the under-<br>lying cause last.   |         |  |  |   |  |   |  |   |  |   |  |
| (b) } DUE TO, OR AS A CONSEQUENCE OF   |         |  |  |   |  |   |  |   |  |   |  |
| (c) }  |         |  |  |   |  |   |  |   |  |   |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).  |         |  |  |   |  |   |  |   |  |   |  |
| 19a. DATE OF OPERATION   |         |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |  |   |  |   |  | 20. AUTOPSY?  |  |
|  |         |  |  |   |  |   |  |   |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input type="checkbox"/> OR<br>CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |         |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR   |  |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) |  |   |  |
|  |         |  |  | P.M. 19   |  |   |  |   |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |         |  |  | 21e. PLACE OF INJURY (AT HOME,<br>STREET, FACTORY, FARM, ETC.)  |  |   |  | 21f. LOCATION   |  |   |  |
|  |         |  |  |   |  |   |  | CITY OR TOWN COUNTY STATE   |  |   |  |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion<br>death resulted from: Natural cause <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |         |  |  |   |  |   |  |   |  |   |  |
| ACTUAL<br>SIGNATURE  |         |  |  | TITLE (SPECIFY)   |  |   |  | DATE<br>SIGNED  |  |   |  |
| Ann M. Dixon, M.D.   |         |  |  | Assistant   |  |   |  | 12-29-79  |  |   |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT)   |         |  |  | ADDRESS   |  |   |  |   |  |   |  |
| Ann M. Dixon, M.D.   |         |  |  | 111 Penn St.  |  |   |  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)   |         |  |  | 23b. DATE   |  | 23c. NAME OF CEMETERY OR CREMATORY                                  |  |   |  | 23d. LOCATION   |  |
| Burial   |         |  |  | 12/31/79  |  | Parkwood Cemetery   |  |   |  | Baltimore, Maryland   |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS   |         |  |  |   |  | 25a. DATE REC'D. BY REGISTRAR                                       |  | 25b. REGISTRAR'S SIGNATURE  |  |   |  |
| Duda-Ruck, Inc.<br>7922 Wise Avenue, Dundalk, MD 21222   |         |  |  |   |  | JAN 3 1980  |  | R. J. Kelly   |  |   |  |



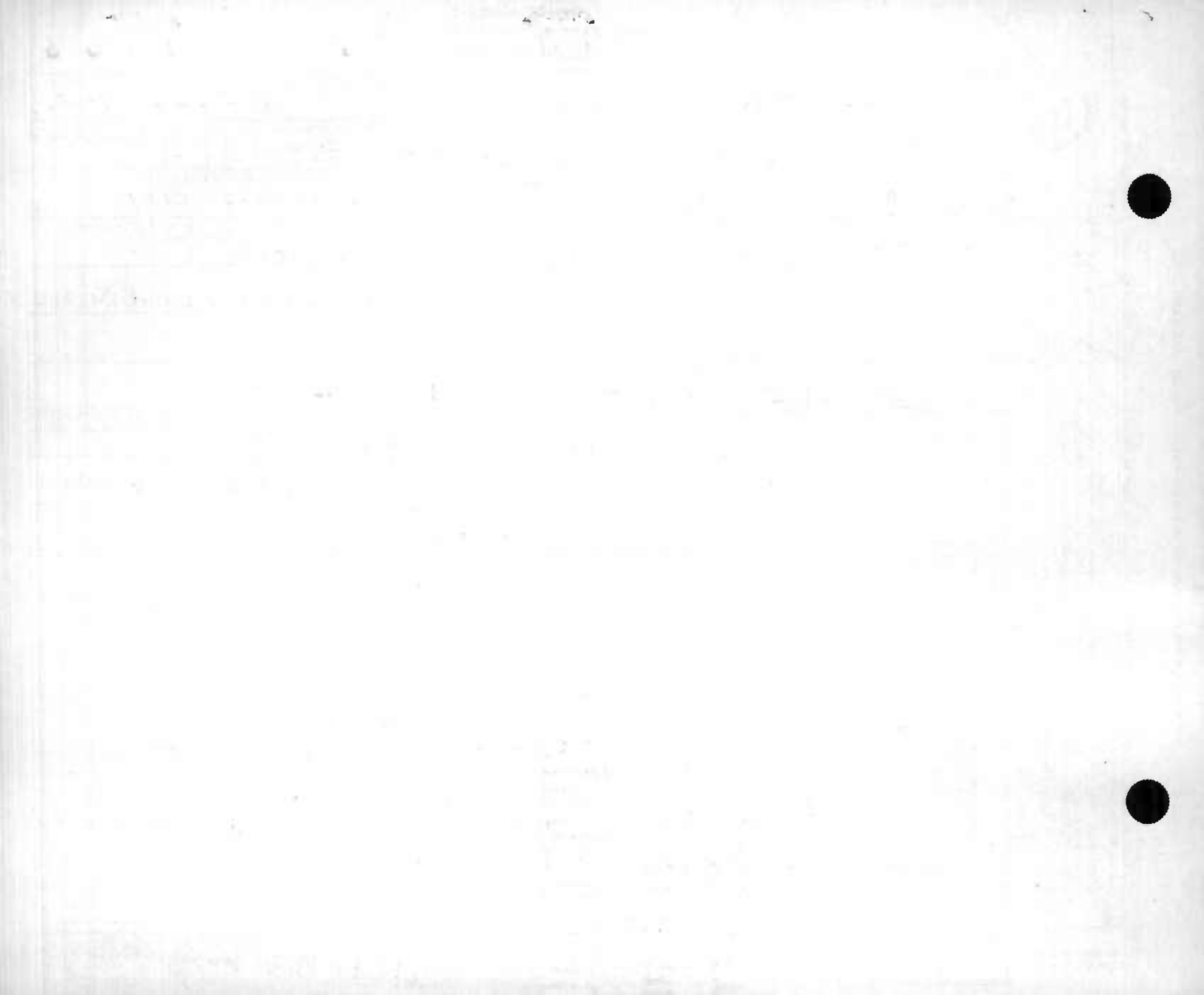


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  |   |  |   |  |   |  | 7 9 3 0 5 6 3<br>REG. NO.                                  |  |
|---|--|---|--|---|--|---|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |  | FIRST<br>CLAYTON  |  | MIDDLE<br>RORIE   |  | LAST  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>12-7-79  |  | 2b. HOUR<br>8-20 P.M.                                      |  |
| 3. SEX<br>MALE  |  | 4. RACE<br>BLACK  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>2 25 1920   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>59 YRS.  |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.  |  | 8. IF UNDER 24 HRS<br>HOURS MIN.                           |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>South CAROLINA   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD.                                      |  |   |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>SINAI HOSPITAL OF BALTO. |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Beth STEEL                  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>-  |  |  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |   |  |   |  |   |  |   |  |  |  |
| 13a. STATE<br>-   |  | 13b. COUNTY<br>-  |  | 13c. CITY OR TOWN<br>-  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br>3222 Cherry Land Rd. 21 225  |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST  |  |   |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST   |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>Yes   |  |   |  |   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>WWT 249-26-3030                      |  | 17. INFORMANT<br>ADDRESS<br>Anna Rorie 3222 Cherry Land Road  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) SMALL CELL CARCINOMA OF<br>1629<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) LUNG & WIDESPREAD<br>(c) metastases.<br>DUE TO, OR AS A CONSEQUENCE OF<br>metastases.              |  |   |  |   |  |   |  |   |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br>6 mths. |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |   |  |   |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION<br>-   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br>-   |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. - 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)<br>-   |  |   |  |   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)<br>-   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 12-7-79 to 12-7-79, that (I) (we) lost<br>saw the deceased alive on 12-7-79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death. |  |   |  |   |  |   |  |   |  |  |  |
| 22b. SIGNATURE<br>Asnani. 9159.   |  | DEGREE<br>M.D.  |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>                  |  |   |  | 22c. DATE SIGNED<br>12-7-1979   |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>HARESH ASNANI  |  |   |  |   |  | 22e. ADDRESS<br>SINAI HOSPITAL OF BALTIMORE   |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial  |  | 23b. DATE<br>12/12/1979   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Cedar Hill Cemetery   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Anne Arundel Co., Maryland                        |  |   |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Wm. C. March F/H 1101 East North Avenue   |  |   |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br>DEC 10 1979  |  | 25b. REGISTRAR'S SIGNATURE<br>[Signature]   |  |  |  |



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM. 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |  |   |  |  |   |   |  |   |   | REG. NO. 30564                               |          |
|--|--|---|--|--|---|---|--|---|---|--|----------|
| 1. FOR STATE REGISTRAR   |  | 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br>ERNESTINE M. ROSE |  |  |   |   |  |   |   | 2a. DATE KNOWN OF DEATH                      | 2b. HOUR |
| 3. SEX<br>female   |  | 4. RACE<br>white  | 5. DATE OF BIRTH (MONTH DAY YEAR)<br>2-20-1898   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>81 YRS. | IF UNDER 1 YR.<br>MONTHS DAYS   | IF UNDER 24 HRS.<br>HOURS MIN.  | 2c. DATE PRONOUNCED DEAD<br>12 3 1979                      | 2d. HOUR<br>4:30                                      |   |  |          |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>New York  |  |   | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD. |   |   |  |          |
| 10. CITY OR TOWN OF DEATH<br>Baltimore   |  |   | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>3409 Royston Ave. |  |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Home Maker                     |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>U.S.A.           |   |  |          |
| 13a. STATE<br>Md.  |  | 13b. COUNTY   |  | 13c. CITY OR TOWN<br>Balto.                |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br>3409 Royston Avenue            |   |  |          |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>Unknown   |  |   |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Unknown   |   |  |   |   |  |          |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)<br>No   |  |   | 16b. SOCIAL SECURITY NO.<br>213-07-3744  |  | 17. INFORMANT ADDRESS<br>Mr. Harold M. O'Dell - 3409 Royston Ave. 21214   |   |  |   |   |  |          |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY: Arteriosclerotic cardiovascular disease<br>IMMEDIATE CAUSE (a): 4292<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost:<br>(b):<br>(c):<br>DUE TO, OR AS A CONSEQUENCE OF<br>DUE TO, OR AS A CONSEQUENCE OF   |  |   |  |  |   |   |  |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |          |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).  |  |   |  |  |   |   |  |   |   |  |          |
| 19a. DATE OF OPERATION   |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |  |   |   |  |   | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |          |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |  |   | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)                   |  |   |   |  |          |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |   | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)  |  |   | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |   |   |  |          |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |  |   |  |  |   |   |  |   |   |  |          |
| ACTUAL SIGNATURE<br>Ann M. Dixon   |  |   | TITLE (SPECIFY)<br>Assistant   |  |   | MEDICAL EXAMINER<br>111 Penn St.  |  |   | DATE SIGNED<br>12-3-79  |  |          |
| EXAMINER'S NAME (TYPE OR PRINT)<br>Ann M. Dixon, M.D.  |  |   | ADDRESS  |  |   |   |  |   |   |  |          |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial  |  |   | 23b. DATE<br>12-4-79   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Baltimore National Cen.   |   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br>Balto. Md. |   |  |          |
| 24. FUNERAL DIRECTOR<br>John C. Miller Inc-6415 Belair Rd.-21206   |  |   |  |  |   | 25a. DATE REC'D BY REGISTRAR<br>DEC 6 1979  |  | 25b. REGISTRAR'S SIGNATURE<br>[Signature]             |   |  |          |

|                 |  |             |  |                |  |
|-----------------|--|-------------|--|----------------|--|
| 1. NAME OF LAND |  | 2. LOCATION |  | 3. DATE        |  |
| 4. AREA         |  | 5. OWNER    |  | 6. COMMENTS    |  |
| 7. DESCRIPTION  |  | 8. MAP      |  | 9. NOTES       |  |
| 10. SURVEY      |  | 11. RECORD  |  | 12. SIGNATURE  |  |
| 13. TITLE       |  | 14. NUMBER  |  | 15. DATE       |  |
| 16. DESCRIPTION |  | 17. MAP     |  | 18. NOTES      |  |
| 19. SURVEY      |  | 20. RECORD  |  | 21. SIGNATURE  |  |
| 22. TITLE       |  | 23. NUMBER  |  | 24. DATE       |  |
| 25. DESCRIPTION |  | 26. MAP     |  | 27. NOTES      |  |
| 28. SURVEY      |  | 29. RECORD  |  | 30. SIGNATURE  |  |
| 31. TITLE       |  | 32. NUMBER  |  | 33. DATE       |  |
| 34. DESCRIPTION |  | 35. MAP     |  | 36. NOTES      |  |
| 37. SURVEY      |  | 38. RECORD  |  | 39. SIGNATURE  |  |
| 40. TITLE       |  | 41. NUMBER  |  | 42. DATE       |  |
| 43. DESCRIPTION |  | 44. MAP     |  | 45. NOTES      |  |
| 46. SURVEY      |  | 47. RECORD  |  | 48. SIGNATURE  |  |
| 49. TITLE       |  | 50. NUMBER  |  | 51. DATE       |  |
| 52. DESCRIPTION |  | 53. MAP     |  | 54. NOTES      |  |
| 55. SURVEY      |  | 56. RECORD  |  | 57. SIGNATURE  |  |
| 58. TITLE       |  | 59. NUMBER  |  | 60. DATE       |  |
| 61. DESCRIPTION |  | 62. MAP     |  | 63. NOTES      |  |
| 64. SURVEY      |  | 65. RECORD  |  | 66. SIGNATURE  |  |
| 67. TITLE       |  | 68. NUMBER  |  | 69. DATE       |  |
| 70. DESCRIPTION |  | 71. MAP     |  | 72. NOTES      |  |
| 73. SURVEY      |  | 74. RECORD  |  | 75. SIGNATURE  |  |
| 76. TITLE       |  | 77. NUMBER  |  | 78. DATE       |  |
| 79. DESCRIPTION |  | 80. MAP     |  | 81. NOTES      |  |
| 82. SURVEY      |  | 83. RECORD  |  | 84. SIGNATURE  |  |
| 85. TITLE       |  | 86. NUMBER  |  | 87. DATE       |  |
| 88. DESCRIPTION |  | 89. MAP     |  | 90. NOTES      |  |
| 91. SURVEY      |  | 92. RECORD  |  | 93. SIGNATURE  |  |
| 94. TITLE       |  | 95. NUMBER  |  | 96. DATE       |  |
| 97. DESCRIPTION |  | 98. MAP     |  | 99. NOTES      |  |
| 100. SURVEY     |  | 101. RECORD |  | 102. SIGNATURE |  |



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

7 9 3 0 5 6 5  
REG. NO.

1. FOR  
STATE  
REGISTRAR

|   |  |  |  |  |  |   |   |  |
|---|--|--|--|--|--|---|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>SELMA ROSENBAUM  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>DEC 17 1979 |  |  | 2b. HOUR<br>9 48 AM   |   |  |
| 3 SEX<br>FEMALE   |  | 4 RACE<br>WHITE  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>JUNE 7 1901  |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br>78 YRS  |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>MARYLAND   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  |  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD.                                       |   |  |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>UNION MEMORIAL HOSPITAL |  |  | 12a. USUAL OCCUPATION<br>(TYPE OR WORK FOR MOST OF WORKING LIFE)<br>DEPT. HEAD |   | 12b. KIND OF BUSINESS OR INDUSTRY<br>DRY GOODS  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |  |  |  |  |   |   |  |
| 13a. STATE<br>MARYLAND  |  | 13b. COUNTY  |  | 13c. CITY OR TOWN<br>BALTIMORE   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   |  |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br>BEN ZION ROSENBAUM   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE<br>DORA ROSENBAUM   |  | 13e. STREET ADDRESS<br>113 W. UNIVERSITY PKWY. #21218 APT.   |  |   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>NO  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)  |  | 17 INFORMANT<br>MRS. MARCIA WEISKOPF<br>3402 HATTON RD. BALTO., MD 21208   |  |   |   |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE<br>410 - Acute myocardial infarction<br>DUE TO, OR AS A CONSEQUENCE OF<br>b. Arteriosclerotic heart disease<br>DUE TO, OR AS A CONSEQUENCE OF<br>c. 4 years.                                   |  |  |  |  |  |   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br>4 years.   |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)  |  |  |  |  |  |   |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>      |   | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |   |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |   |   |  |
| 22a. I certify that (I) (the hospital) attended the deceased from June 1975, 19 to Dec 1979, 19, that (I) (we) lost<br>saw the deceased alive on 19 Dec 1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above. (If (we) (did) (did not) view the body after death. |  |  |  |  |  |   |   |  |
| 22b. SIGNATURE<br>DR. STANSBURY, M.D.   |  |  |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>       |  | 22c. DATE SIGNED<br>12/7/79   |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  |  |  | 22e. ADDRESS<br>Union Memorial Hosp.   |  |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>BURIAL  |  | 23b. DATE<br>DEC. 18, 1979   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>BALTIMORE HEBREW   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>BALTIMORE MARYLAND                                |   |  |
| 24 FUNERAL DIRECTOR<br>NAME<br>SOL LEVINSON & BROS., INC.<br>6010 REISTERSTOWN RD. BALTO., MD 21215   |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br>DEC 20 1979   |  | 25b. REGISTRAR'S SIGNATURE<br>Hickory McCreedy  |   |  |

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death, and retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| 1 - FOR STATE REGISTRAR   |  | STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  | REG. NO. 79 30566  |  |
|---|--|---|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT)  |  | FIRST MIDDLE LAST<br>HATTIE J. ROSS   |  | 2a. DATE OF DEATH MONTH DAY YEAR 12-2-79 2b. HOUR 1:45 PM                                    |  |
| 3. SEX Female   |  | 4. RACE Negro   |  | 5. DATE OF BIRTH MONTH DAY YEAR 1 6 1884   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland  |  | 7b. CITIZEN OF WHAT COUNTRY? U. S. A.   |  | 6. AGE (IN YEARS LAST BIRTHDAY) 95 YRS   |  |
| 10. CITY OR TOWN OF DEATH Baltimore   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Lutheran Hospital                          |  | 9. BALTIMORE CITY OR COUNTY OF DEATH City MD.  |  |
| 13a. STATE Maryland   |  | 13b. COUNTY Baltimore   |  | 13c. CITY OR TOWN Baltimore  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST Franklin Henry  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Alice Haskins  |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)   |  | 16b. SOCIAL SECURITY NO.  |  | 17. INFORMANT ADDRESS Charles Brown 2109 North Fulton Avenue                                 |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) 7854 gangrene of left foot<br>DUE TO, OR AS A CONSEQUENCE OF (b)<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (c)<br>DUE TO, OR AS A CONSEQUENCE OF (c) |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)               |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 11-17-79 to 12-2-79, that (I) (we) lost above (we) (did) (did not) view the body after death.  |  |   |  |  |  |
| 22b. SIGNATURE Thomas M. Walsh MD   |  | DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED 12-2-79   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) THOMAS M. WALSH MD  |  | 22e. ADDRESS 730 Ashburton Street Baltimore   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial  |  | 23b. DATE 12/5/1979   |  | 23c. NAME OF CEMETERY OR CREMATORY Arbutus Mem. Park   |  |
| 23d. LOCATION CITY OR TOWN COUNTY STATE Arbutus, Maryland   |  | 24. FUNERAL DIRECTOR NAME ADDRESS Wm. C. March F/H 1101 East North Avenue   |  |  |  |
| 25a. DATE REC'D. BY REGISTRAR DEC 5 1979  |  | 25b. REGISTRAR'S SIGNATURE [Signature]  |  |  |  |

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*[Faint, illegible handwriting on lined paper]*

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REG. NO.

1 - FOR  
STATE  
REGISTRAR

|  |  |   |  |   |  |
|--|--|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>JESSE</b>  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>12 / 2 / 79</b>   |  | 2b. HOUR<br><b>257 P.M.</b>   |  |
| 3. SEX<br><b>M</b>   |  | 4. RACE<br><b>B</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>12 9 04</b>  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>UA.</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALT. CITY</b>   |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALT</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>LUTHERAN HOSPITAL</b> |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>—</b>  |  |
| 13a. STATE<br><b>MD.</b>   |  | 13b. COUNTY<br><b>BALT. CITY</b>  |  | 13c. CITY OR TOWN<br><b>BALT. CITY</b>  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Edward — Ross</b>   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>JADIANA — LAURENCE</b>  |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO —</b>   |  |
| 16b. SOCIAL SECURITY NO.<br><b>229-07-7264</b>   |  | 17. INFORMANT<br>ADDRESS<br><b>Carrie Miles 1627 Ruxton Avenue</b>  |  | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>VENTRICULAR FIBRILLATION</b><br>(b) <b>CPD</b><br>(c) <b>—</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>DUE TO, OR AS A CONSEQUENCE OF<br>DUE TO, OR AS A CONSEQUENCE OF |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>12/2/79</b> , 19____, to <b>12/2/79</b> , 19____, the (I) (we) lost <b>Edward Koza</b> alive on <b>12/2/79</b> , 19____, and that in my (our) opinion death occurred on the date and hour and from the causes stated above (we did) (did not) view the body after death. |  | 22b. SIGNATURE<br><b>Edward Koza MD</b><br>DEGREE<br><b>MD</b>  |  | 22c. DATE SIGNED<br><b>12/2/79</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>EDWARD KOZA MD</b>   |  | 22e. ADDRESS<br><b>LUTHERAN HOSPITAL</b>  |  | 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>  |  |
| 23b. DATE<br><b>12/7/1979</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>King Memorial Park</b>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Co., Maryland</b>  |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Wm. C. March F/H 1101 East North Avenue</b>   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>DEC 4 1979</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>Anthony Melvin</b>   |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers; Pages 1 and 2 should be filed with the Registrar of Deaths with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

**IMPORTANT:** If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| 1- FOR STATE REGISTRAR  |  |   |  | STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  | 7 9 3 0 5 6 8<br>REG. NO.                                     |  |  |  |
|---|--|---|--|--|--|--|--|---|--|--|--|
| 1 DECEASED NAME<br>(TYPE OR PRINT)  |  |   |  | 2a DATE OF DEATH   |  |  |  | 2b HOUR   |  |  |  |
| FIRST MIDDLE LAST<br>LAWERNCE F. ROSS   |  |   |  | MONTH DAY YEAR<br>12-6-79  |  |  |  | 2:35AM M  |  |  |  |
| 3 SEX   |  | 4 RACE  |  | 5 DATE OF BIRTH  |  | 6 AGE (IN YEARS LAST BIRTHDAY)   |  | 7 UNDER 1 YEAR  |  | 7 UNDER 24 HRS                               |  |
| MALE  |  | WHITE   |  | MONTH DAY YEAR<br>7 16-1910  |  | 69 YRS   |  | MONTHS DAYS   |  | HOURS MIN                                    |  |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  | 7b CITIZEN OF WHAT COUNTRY?   |  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH  |  |   |  |  |  |
| MARYLAND  |  | U.S.A.  |  |  |  | BALTIMORE CITY MD.   |  |   |  |  |  |
| 10 CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |  |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)                               |  | 12b. KIND OF BUSINESS OR INDUSTRY                             |  |  |  |
| BALTO   |  | CHURCH HOME & HOSP  |  |  |  | MEE-SEAMAN   |  | NATIONAL MAR.   |  |  |  |
| 13a USUAL RESIDENCE<br>(IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  | 13b COUNTY  |  | 13c CITY OR TOWN   |  | 13d INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e STREET ADDRESS  |  |  |  |
| MD  |  |   |  | BALTO  |  | YES  |  | 8889 EASTERN AVE  |  |  |  |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST   |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST  |  |  |  |   |  |  |  |
| ROSS  |  |   |  | UNKNOWN  |  |  |  |   |  |  |  |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)   |  | 16b SOCIAL SECURITY NO.   |  | 17 INFORMANT   |  | ADDRESS  |  |   |  |  |  |
| YES   |  | 213-01-1837   |  | LITA HUGHES  |  | 900 W. 37th ST   |  |   |  |  |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) ACUTE RESPIRATORY FAILURE<br>5621<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) 8 ASPIRATION PNEUMONIA, GASTRO INTESTINAL BLEEDING<br>(c) ACUTE DIVERTICULITIS<br>DUE TO, OR AS A CONSEQUENCE OF<br>PSEUDOMONAS PNEUMONIA<br>GASTRO INTESTINAL |  |   |  |  |  |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)<br>BLEEDING; PHLETHROTHROMBOSIS, LEGS; PERITONITIS SIGMOID  |  |   |  |  |  |  |  |   |  |  |  |
| 19a DATE OF OPERATION   |  | 19b CONDITION FOR WHICH OPERATION WAS DONE  |  |  |  | 20a AUTOPSY?   |  | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |  |  |  |
| 11-9-79   |  | ACUTE DIVERTICULITIS SIGMOID OBSTRUCTION  |  |  |  | YES <input checked="" type="checkbox"/> NO <input checked="" type="checkbox"/>                 |  | YES <input type="checkbox"/> NO <input type="checkbox"/>      |  |  |  |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |  |  |  |   |  |  |  |
| 21d INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                     |  | 21f LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |   |  |  |  |
|   |  |   |  |  |  |  |  |   |  |  |  |
| 22a I certify that (I) (this hospital) attended the deceased from 11-8 19 79, to 12-6 19 79, that (I) (we) last saw the deceased alive on 12-6 19 79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |   |  |  |  |  |  |   |  |  |  |
| 22b SIGNATURE   |  |   |  | DEGREE   |  |  |  | 22c DATE SIGNED   |  |  |  |
| Sompalli Phras  |  |   |  |  |  |  |  |   |  |  |  |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT)  |  |   |  | 22e ADDRESS  |  |  |  |   |  |  |  |
| XXXXXX XXXXX SOMPALLI, S. K.  |  |   |  | CHURCH HOSPITAL CORPORATION 100 N. BROADWAY BALTIMORE, MARYLAND 21231  |  |  |  |   |  |  |  |
| 23a BURIAL, CREMATION, REMOVAL<br>(SPECIFY)   |  | 23b DATE  |  | 23c NAME OF CEMETERY OR CREMATORY  |  | 23d LOCATION<br>CITY OR TOWN COUNTY STATE  |  |   |  |  |  |
| CREMATION   |  | 12-10-79  |  | WESTVIEW CEM   |  | BALTO MD   |  |   |  |  |  |
| 24 FUNERAL DIRECTOR<br>NAME ADDRESS   |  |   |  | 25a DATE REC'D. BY REGISTRAR   |  | 25b REGISTRAR'S SIGNATURE  |  |   |  |  |  |
| JOHN M. WEBER & SONS INC. CHESTER   |  |   |  | 10 1979  |  | R. J. McCready   |  |   |  |  |  |



X

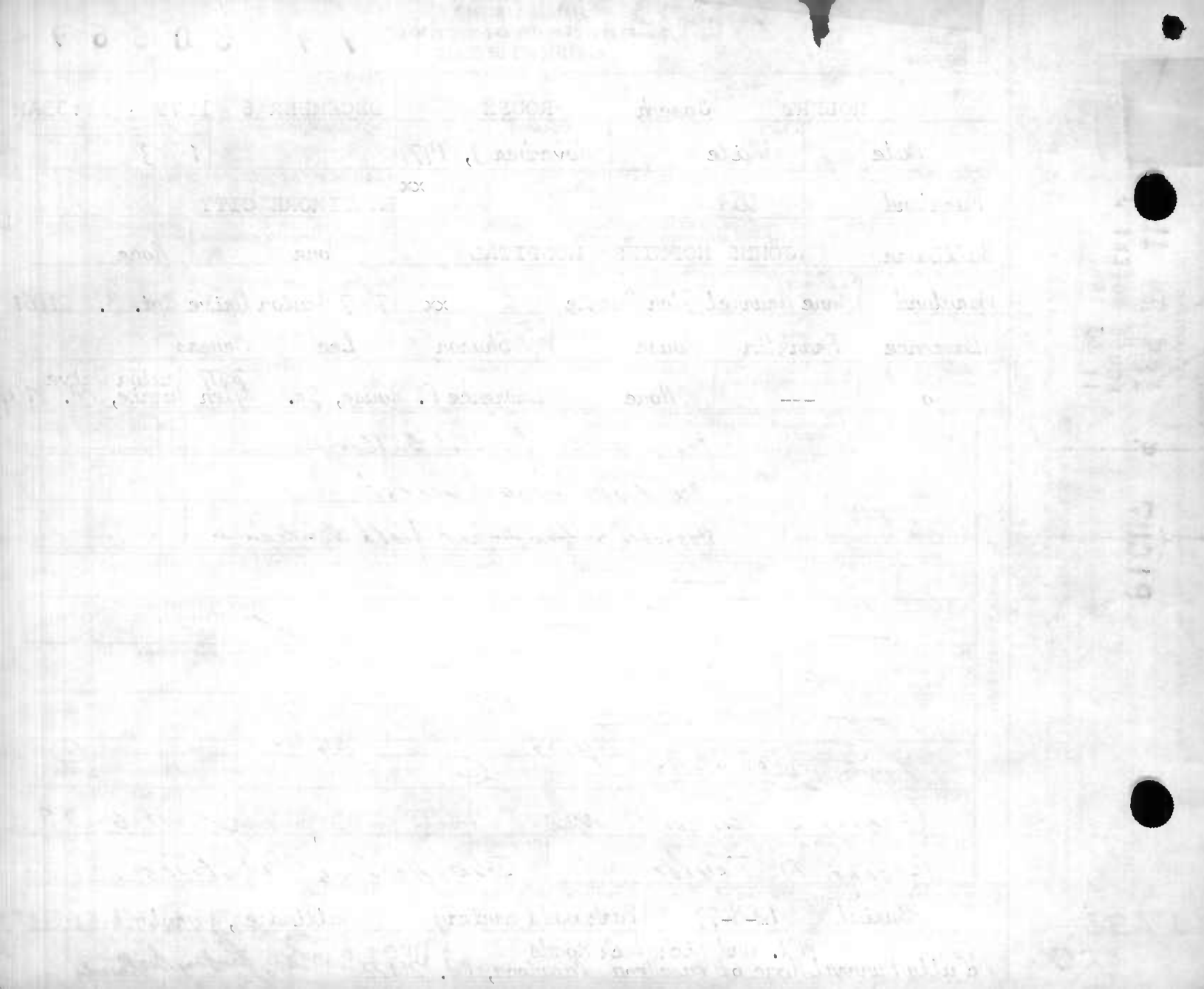
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and properly filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  |  |   |  |  |   |   | 7930569 |  |
|---|--|--|--|--|---|--|--|---|---|---------|--|
| 1. FOR<br>STATE<br>REGISTRAR  |  | REG. NO.   |  |  |   |  |  |   |   |         |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>ROBERT Joseph ROUSE</b>  |  |  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR <b>DECEMBER 6 1979</b>                                      |  |  | 2b. HOUR<br><b>11:35AM</b>  |   |         |  |
| 3. SEX<br><b>Male</b>   |  | 4. RACE<br><b>White</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR <b>November 3, 1979</b>   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>YRS. MONTHS DAYS <b>7 3</b>                       |  | 7. IF UNDER 1 YEAR<br>HOURS MIN <b>11:35</b>  |   |         |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.                    |  |   |   |         |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>JOHNS HOPKINS HOSPITAL</b> |  |  |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>None</b>      |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>None</b>  |   |         |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE <b>Maryland</b> 13b. COUNTY <b>Anne Arundel</b> 13c. CITY OR TOWN <b>Glen Burnie</b>   |  |  |  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>7807 Braiton Drive Apt. B. 21061</b> |   |   |         |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST <b>Lawrence Franklin Rouse</b>   |  |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST <b>Sharon Lee Meyers</b>                          |  |  |   |   |         |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>No</b>  |  | 16b. SOCIAL SECURITY NO<br>(IF YES, GIVE WAR OR DATES) <b>None</b>   |  | 17. INFORMANT ADDRESS<br><b>Lawrence F. Rouse, Jr. 7807 Braiton Drive Glen Burnie, Md. 21061</b>   |   |  |  |   |   |         |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Progressive Cerebral DEGENA</b><br><b>7980</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Pneidiopulmonary arrest.</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Possible Sudden Infant Death Syndrome</b> |  |  |  |  |   |  |  |   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |         |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |  |  |  |   |  |  |   |   |         |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |         |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |   |  |  |   |   |         |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |   |  |  |   |   |         |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>12/2/79</b> 19, to <b>12/6/79</b> 19, that (I) (we) last saw the deceased alive on <b>12/6/79</b> 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.              |  |  |  |  |   |  |  |   |   |         |  |
| 22b. SIGNATURE<br><b>George A. Taylor MD</b>  |  |  |  |  | DEGREE <b>MD</b>  |  |  | 22c. DATE SIGNED<br><b>12-6-79</b>  |   |         |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>George D. Taylor</b>  |  |  |  |  | 22e. ADDRESS<br><b>Johns Hopkins Pediatrics</b>   |  |  |   |   |         |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY) <b>Burial</b>  |  | 23b. DATE<br><b>12-8-79</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Parkwood Cemetery</b>   |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE <b>Baltimore, Maryland</b>                |  |   |   |         |  |
| 24. FUNERAL DIRECTOR<br>NAME <b>Mt. and Tid Neck Roads</b><br><b>Mcully Funeral Home of Pasadena Pasadena, Md.</b>  |  |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>DEC 11 1979</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>Robert M. Brandy</b>          |   |   |         |  |

BP





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

|   |   |  |   |
|---|---|--|---|
| Item 18b G540 2/22/80 dad   |   | STATE OF MARYLAND  |   |
| FOR<br>1- STATE<br>REGISTRAR  |   | DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |   |
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |   | 2a. DATE OF DEATH  |   |
| FIRST MCKINLEY LAST ROYSTER   |   | MONTH DAY YEAR<br>December 23, 1979  |   |
| 3 SEX   | 4 RACE  | 5. DATE OF BIRTH   | 6 AGE (IN YEARS LAST BIRTHDAY)                                |
| M   | B   | MONTH DAY YEAR<br>5 23 03  | 76 YRS.   |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)  | 7b CITIZEN OF WHAT COUNTRY?   | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9 BALTIMORE CITY OR COUNTY OF DEATH                           |
| N.C.  | USA   |  | Baltimore City MD.  |
| 10 CITY OR TOWN OF DEATH  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | 12a USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)  | 12b KIND OF BUSINESS OR INDUSTRY                              |
| Balto.  | Church Home Hosp.   |  |   |
| 13a STATE   |   | 13b CITY OR TOWN   | 13c INSIDE CITY LIMITS?                                       |
| MD.   | Balto.  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |   |
| 14 FATHER'S NAME  |   | 15 MOTHER'S MAIDEN NAME  |   |
| FIRST MIDDLE LAST   | FIRST MIDDLE LAST   |  |   |
| Jimmy Phelps  | Marley  |  |   |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)   | 16b SOCIAL SECURITY NO  | 17 INFORMANT ADDRESS   |   |
| No  | 718-05-0323   | Maxine V. Brandon 405 N. Collington Ave.   |   |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1: DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) Severe decubitus ulcer ( bleeding and infected)<br>7288<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) Four limbs contractures Left hip Muscle<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost<br>(c) Poor M nutrition |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |   |  |   |
| 19a DATE OF OPERATION   | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED   | 20a AUTOPSY?   | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |
| 12-13-79  | Debridment of decubitus ulcer   | YES <input type="checkbox"/> NO <input type="checkbox"/>   | YES <input type="checkbox"/> NO <input type="checkbox"/>      |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   | 21b TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |   |
| 21d INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  | 21e PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                     | 21f LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |
| 22a I certify that (I) (this hospital) attended the deceased from 12/22 to 12/23/79, that (I) (we) last saw the deceased alive on 12/23 1979 and that (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.   |   |  |   |
| 22b SIGNATURE   | DEGREE  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>                 | 22c DATE SIGNED   |
| H. Al-Midani  | M.D.  |  | 12/23/79  |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT)  | 22e ADDRESS   |  |   |
| H. Al-Midani  | Church Hospital   |  |   |
| 23a BURIAL, CREMATION, REMOVAL<br>(SPECIFY)   | 23b DATE  | 23c NAME OF CEMETERY OR CREMATOR   | 23d LOCATION<br>CITY OR TOWN COUNTY STATE                     |
| Burial  | 12/28/79  | Macedona Med. Church   | Semora N.C.   |
| 24 FUNERAL DIRECTOR<br>NAME   | 24b ADDRESS   |  | 25a DATE REC'D. BY REGISTRAR                                  |
| William C. March F.H.   | 1101 E. North Ave.  |  | DEC 26 1979   |
| 25b REGISTRAR'S SIGNATURE   |   |  |   |
| [Signature]   |   |  |   |

DEC 28 1973



DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

7 9 3 0 5 7 1

1. FOR  
STATE  
REGISTRAR

|  |  |   |   |  |  |   |  |   |  |
|--|--|---|---|--|--|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>MINNIE</b>  |  |   | 2a. DATE OF DEATH<br>MONTH <b>December</b> DAY <b>26</b> YEAR <b>1979</b> |  |  | 2b. HOUR<br><b>2:05 a.m.</b>  |  |   |  |
| 3 SEX<br><b>Female</b>   |  | 4 RACE<br><b>White</b>  |   | 5 DATE OF BIRTH<br>MONTH <b>August</b> DAY <b>14</b> YEAR <b>1901</b>  |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br><b>78</b> YRS.  |  | 7. IF UNDER 1 YEAR<br>MONTHS <b>0</b> DAYS <b>0</b> HOURS <b>0</b> MIN.       |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY) <b>Virginia</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |   | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.  |  |   |  |
| 10 CITY OR TOWN OF DEATH<br><b>Baltimore</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>3113 Moravia Road</b> |   |  |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Housewife</b>                                  |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |
| 13a. STATE<br><b>Maryland</b>  |  | 13b. COUNTY<br><b>Baltimore</b>   |   | 13c. CITY OR TOWN<br><b>Baltimore</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                       |  | 13e. STREET ADDRESS<br><b>Balt., Md. 21214</b><br><b>3113 Moravia Road</b>    |  |
| 14. FATHER'S NAME<br>FIRST <b>Thomas</b> MIDDLE <b>D.</b> LAST <b>Davidson</b>   |  |   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>Alice</b> MIDDLE <b>L.</b> LAST <b>Carter</b>   |  |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>No</b>   |  |   |   | 16b. SOCIAL SECURITY NO.<br><b>212-36-5039</b>   |  | 17. INFORMANT <b>Daughter:</b> ADDRESS <b>Balt., Md. 21214</b><br><b>Betty M. Hemstetter</b> <b>3113 Moravia Road</b> |  |   |  |
| 18 CAUSE OF DEATH: Enter only one cause per line (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>410 -</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>Arteriosclerosis</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>Arteriosclerosis</b><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 year.</b> |  |   |   |  |  |   |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><b>Leukemia</b>   |  |   |   |  |  |   |  |   |  |
| 19a. DATE OF OPERATION   |  |   |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>     |  |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  |   |   |  |  |   |  |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. <b>19</b>  |  |   |  |   |  |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |   |   |  |  |   |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |   |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  |   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                             |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>1976</b> , to <b>1979</b> , that (I) (we) lost<br>saw the deceased alive on <b>Dec 28</b> , 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did not) view the body after death.   |  |   |   |  |  |   |  |   |  |
| 22b. SIGNATURE<br><b>Dr. Gracito Patricio</b>  |  |   |   | DEGREE<br><b>M.D.</b>  |  |   |  | 22c. DATE SIGNED<br><b>12/27/79</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Dr. Gracito Patricio M.D.</b>  |  |   |   | 22e. ADDRESS<br><b>2926 E. Cold Spring Lane Balt., Md.</b>   |  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY) <b>Burial</b>   |  |   |   | 23b. DATE<br><b>Dec 28 1979</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Baltimore National</b>   |  | 23d. LOCATION<br>CITY OR TOWN <b>Catonsville</b> COUNTY <b>Maryland</b> STATE |  |
| 24. FUNERAL DIRECTOR<br>NAME <b>Leonard J. Ruck, Inc.</b> ADDRESS <b>Baltimore, Maryland</b>   |  |   |   | 25a. DATE REC'D. BY REGISTRAR<br><b>DEC 28 1979</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>  |  |   |  |

83 60 35 300 1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

05-3-11 1:03



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$$100 - 10 = 90$$

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 and 2 should be filed within 72 hours after death. Page 3 should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  |  |   |  |   |  |  | 7930572  |  |
|--|--|--|--|--|---|--|---|--|--|--|--|
| 1. FOR<br>STATE<br>REGISTRAR   |  |  | REG. NO.   |  |   |  |   |  |  |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>THOMAS RUSH   |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>12 27 1979                      |  |   | 2b. HOUR<br>3 25 A M   |   |  |  |  |  |
| 3 SEX<br>Male  |  | 4 RACE<br>Col  |  | 5 DATE OF BIRTH<br>MONTH DAY YEAR<br>2-15-1898   |   | 6 AGE (IN YEARS LAST BIRTHDAY)<br>81 YRS                                       |   | 7. IF UNDER 1 YEAR<br>MONTHS DAYS  |  | 8. IF UNDER 24 HRS<br>HOURS MIN  |  |
| 7a. BIRTHPLACE<br>STATE OR FOREIGN<br>Country<br>S.C.  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A  |  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9 BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD                       |   |  |  |  |  |
| 10 CITY OR TOWN OF DEATH<br>Baltimore  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Providence Hosp |  |  |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Retired    |   |  | 12b. KIND OF BUSINESS OR INDUSTRY              |  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>Maryland   |  |  | 13b. COUNTY<br>Baltimore   |  | 13c. CITY OR TOWN<br>Baltimore                    |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br>727 Druid Park Dr. N.A. |  |  |
| 14 FATHER'S NAME<br>First Middle Last<br>Mitchell Rush   |  |  | 15 MOTHER'S MAIDEN NAME<br>First Middle Last<br>Mary Rush              |  |   |  |   |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No   |  |  | 16b. SOCIAL SECURITY NO.<br>223-03-5474                                |  | 17 INFORMANT<br>Mrs. Mary Brown                   |  |   | ADDRESS<br>2240 Dexter Way   |  |  |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>CARDIORESPIRATORY ARREST</u><br><u>4019</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>CONGESTIVE HEART FAILURE</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>ARTEROSCLEROSIS</u>   |  |  |  |  |   |  |   |  |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br><u>20 minutes</u><br><u>20 YEARS</u><br><u>30 YEARS</u> |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><u>HYPERTENSION</u>  |  |  |  |  |   |  |   |  |  |  |  |
| 19a. DATE OF OPERATION   |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>      |   | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>              |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |   |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |   |  |  |  |  |
| 22. I certify that (I) (this hospital) attended the deceased from <u>December 14</u> , 19 <u>79</u> , to <u>December 27</u> , 19 <u>79</u> , that (I) (we) last saw the deceased alive on <u>December 27</u> , 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |   |  |   |  |  |  |  |
| 22b. SIGNATURE<br><u>William D. no</u>   |  |  |  |  |   | DEGREE   |   | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br>12-27-79   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>A. MIKANDA  |  |  |  |  |   | 22e. ADDRESS<br>PROVIDENT HOSPITAL   |   |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial   |  |  | 23b. DATE<br>1-4-80  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Mt Zion Cem |  |   | 23d. LOCATION<br>CITY OR TOWN COUNTY<br>Baltimore  |  |  |  |
| 24 FUNERAL DIRECTOR<br>NAME<br>Joseph L. Russ  |  |  |  |  |   | ADDRESS<br>2222 W. North Ave   |   | 25a. DATE REC'D. BY REGISTRAR<br>JAN 7 1980  |  | 25b. REGISTRAR'S SIGNATURE<br>Hickey, K. Brady   |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

79 30573

|   |  |   |  |   |  |  |  |   |  |                             |  |     |  |      |  |          |  |
|---|--|---|--|---|--|--|--|---|--|-----------------------------|--|-----|--|------|--|----------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |  | FIRST   |  | MIDDLE  |  | LAST   |  | 2a. DATE OF DEATH   |  | MONTH                       |  | DAY |  | YEAR |  | 2b. HOUR |  |
| MAGGIE D. RYAL S  |  |   |  |   |  |  |  | Dec 07 79   |  |                             |  |     |  |      |  | 7:15A M  |  |
| 3. SEX  |  | 4. RACE   |  | 5. DATE OF BIRTH  |  | 6. AGE (IN YEARS LAST BIRTHDAY)  |  | IF UNDER 1 YEAR   |  | IF UNDER 24 HRS             |  |     |  |      |  |          |  |
| FEMALE  |  | Black   |  | MONTH DAY YEAR<br>4 5 03  |  | 76 YRS   |  | MONTHS DAYS   |  | HOURS MIN                   |  |     |  |      |  |          |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  | 7b. CITIZEN OF WHAT COUNTRY?  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH   |  |   |  |                             |  |     |  |      |  |          |  |
| Georgia   |  | USA   |  |   |  | Baltimore City MD.   |  |   |  |                             |  |     |  |      |  |          |  |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)  |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |   |  |                             |  |     |  |      |  |          |  |
| Baltimore   |  | Bon Secours Hospital  |  |   |  |  |  |   |  |                             |  |     |  |      |  |          |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  | 13a. STATE  |  | 13b. COUNTY   |  | 13c. CITY OR TOWN  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS         |  |     |  |      |  |          |  |
| Maryland  |  |   |  |   |  | Baltimore  |  |   |  | 3800 West Belvedere Apt-408 |  |     |  |      |  |          |  |
| 14. FATHER'S NAME   |  | MIDDLE  |  | LAST  |  | 15. MOTHER'S MAIDEN NAME   |  | MIDDLE  |  | LAST                        |  |     |  |      |  |          |  |
| Henry   |  |   |  | McLemore  |  | Renda  |  |   |  | Davis                       |  |     |  |      |  |          |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)   |  | 17. INFORMANT   |  | ADDRESS  |  |   |  |                             |  |     |  |      |  |          |  |
|   |  | 219-12-6109   |  | Cleo Banks  |  | 3923 Edmondson Avenue  |  |   |  |                             |  |     |  |      |  |          |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <u>Cerebral infarction</u><br>4340<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) _____<br>(c) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>DUE TO, OR AS A CONSEQUENCE OF       |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |   |  |  |  |   |  |                             |  |     |  |      |  |          |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a:  |  |   |  |   |  |  |  |   |  |                             |  |     |  |      |  |          |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |   |  |                             |  |     |  |      |  |          |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |  |  |  |   |  |                             |  |     |  |      |  |          |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |   |  |                             |  |     |  |      |  |          |  |
| 22a. I certify that (this hospital) attended the deceased from <u>11/28</u> 19 <u>79</u> , to <u>12/07</u> 19 <u>79</u> , that (I) <u>yes</u> last saw the deceased alive on <u>Dec 07</u> 19 <u>79</u> , and that in (my) <u>own</u> opinion death occurred on the date and hour and from the causes stated above, (I) <u>did</u> (did not) view the body after death. |  |   |  |   |  |  |  |   |  |                             |  |     |  |      |  |          |  |
| 22b. SIGNATURE<br>Kuang - yen Huang M.D.  |  | DEGREE  |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>                  |  | 22c. DATE SIGNED<br>12/07/79   |  |   |  |                             |  |     |  |      |  |          |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>HUANG KUANG-YEN  |  | 22e. ADDRESS<br>BON Secours Hospital 21223  |  |   |  |  |  |   |  |                             |  |     |  |      |  |          |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial   |  | 23b. DATE<br>12/12/1979   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Arbutus Memorial Park   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE   |  |   |  |                             |  |     |  |      |  |          |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Wm. C. March F/H 1101 East North Avenue   |  | ADDRESS   |  | 25a. DATE REC'D. BY REGISTRAR<br>DEC 10 1979  |  | 25b. REGISTRAR'S SIGNATURE<br>[Signature]  |  |   |  |                             |  |     |  |      |  |          |  |



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## MEDICAL CERTIFICATION

| 1. FOR STATE REGISTRAR   |  | STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  | REG. NO. 7 9 3 0 5 7 4   |  |
|--|--|--|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) <b>RYLAND, William</b>  |  | 2a. DATE OF DEATH MONTH <b>12</b> DAY <b>14</b> YEAR <b>79</b>   |  | 2b. HOUR <b>5:00 P.M.</b>  |  |
| 3 SEX <b>M</b>   | 4 RACE <b>B</b>  | 5. DATE OF BIRTH MONTH <b>12</b> DAY <b>20</b> YEAR <b>13</b>  |  | 6 AGE (IN YEARS LAST BIRTHDAY) <b>66</b> YRS   |  |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>USA</b>  | 7b CITIZEN OF WHAT COUNTRY? <b>USA</b>   | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD                                 |  |
| 10 CITY OR TOWN OF DEATH <b>Baltimore</b>  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>SBG 14</b> | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Unemployed</b>   |  | 12b KIND OF BUSINESS OR INDUSTRY   |  |
| 13a. STATE <b>MD</b>   |  | 13b. COUNTY <b>B. City</b>   |  | 13c. CITY OR TOWN  |  |
| 14 FATHER'S NAME FIRST <b>Joseph</b> MIDDLE <b>Ryland</b> LAST <b>Ryland</b>   |  | 15 MOTHER'S MAIDEN NAME FIRST <b>Elizabeth</b> MIDDLE <b>UNK.</b> LAST <b>UNK.</b>   |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>   |  | 16b SOCIAL SECURITY NO. <b>218-14-9853</b>   |  | 17 INFORMANT ADDRESS <b>Brother - 2846 BROOKER DR</b>  |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>CARDIAC failure</b><br><b>1629</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(b) <b>CA. OF Lung</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Renal Insufficiency</b> |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).   |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)         |  |  |  |
| 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |  |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>Sept. 20</b> , 19 <b>79</b> , to <b>Dec 14</b> , 19 <b>79</b> , that (I) (we) last saw the deceased alive on <b>Dec 14</b> , 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                         |  |  |  |  |  |
| 22b. SIGNATURE <b>Brunno MD</b>  |  | DEGREE   |  | 22c. DATE SIGNED <b>Dec 14, 1979</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Queen Biviano</b>   |  | 22e. ADDRESS <b>S.B.G.H. HANOVER ST BAIT.</b>  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>  |  | 23b. DATE <b>12-19-79</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY <b>CEDAR HILL</b>   |  |
| 23d. LOCATION (CITY OR TOWN) <b>BALTO</b>  |  | COUNTY <b>MD</b>   |  | STATE  |  |
| 24 FUNERAL DIRECTOR NAME <b>Margaretta R Brown</b>   |  | ADDRESS <b>3106 Wallbrook</b>  |  | 25a. DATE REC'D. BY REGISTRAR <b>DEC 17 1979</b>   |  |
|  |  |  |  | 25b. REGISTRAR'S SIGNATURE <b>Robert J. Brady</b>  |  |

BP

RECEIVED

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| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  |  |  |   |  |  |  |
|---|--|--|--|--|--|---|--|--|--|
| 1. FOR STATE REGISTRAR  |  | 7 9 3 0 5 7 5  |  | REG. NO.   |  |   |  |  |  |
| 1. DECEASED NAME (TYPE OR PRINT)  |  | FIRST MIDDLE LAST  |  | 2a. DATE OF DEATH MONTH DAY YEAR   |  | 2b. HOUR  |  | P  |  |
| JOHN JOSEPH SAAL  |  |  |  | 12 23 79   |  | 5:25  |  | M  |  |
| 3. SEX  |  | 4. RACE  |  | 5. DATE OF BIRTH MONTH DAY YEAR  |  | 6. AGE (IN YEARS LAST BIRTHDAY)                                     |  | IF UNDER 1 YEAR MONTHS DAYS                                    |  |
| Male  |  | White  |  | 8/20/1914  |  | 65  |  | YRS.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |  |  |  |
| Maryland  |  | U.S.A.   |  |  |  | Baltimore City MD.  |  |  |  |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)       |  | 12b. KIND OF BUSINESS OR INDUSTRY                              |  |
| Baltimore   |  | 3415 Falls Rd. 21211   |  |  |  | Crane Operator  |  | Steel Fabricators  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  | 13a. STATE   |  | 13b. CITY OR TOWN  |  | 13d. INSIDE CITY LIMITS?  |  | 13e. STREET ADDRESS  |  |
| Md.   |  | -----  |  | Baltimore  |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 3415 Falls Rd. 21211   |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST   |  |  |  |   |  |  |  |
| Conrad Saal   |  | Anna Schenlein   |  |  |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)   |  | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT ADDRESS  |  |   |  |  |  |
| No  |  | 216.01.4812  |  | Eliz. M. Saal---Same as 13e  |  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>REFRACTORY CONGESTIVE HEART FAILURE</u><br><u>4280</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____  |  |  |  |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>1 month</u> |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS <u>CONTRIBUTING TO DEATH</u> BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |  |  |  |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?      |  |  |  |
|   |  |  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | YES <input type="checkbox"/> NO <input type="checkbox"/>            |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |   |  |  |  |
|   |  | P.M. 19  |  |  |  |   |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  | 21f. LOCATION STREET   |  | CITY OR TOWN  |  | COUNTY STATE   |  |
|   |  |  |  |  |  |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>11/30</u> , 19 <u>78</u> , to <u>12/23</u> , 19 <u>79</u> , that (I) (we) lost<br>saw the deceased alive on <u>12/23</u> , 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above. (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |   |  |  |  |
| 22b. SIGNATURE  |  | DEGREE   |  | 22c. DATE SIGNED   |  |   |  |  |  |
| <u>James D. Ballant M.D.</u>  |  |  |  | 12/24/79   |  |   |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  | 22e. ADDRESS   |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>               |  |   |  |  |  |
| JAMES D. BALLANT M.D.   |  | UNION MEMORIAL HOSPITAL; BALTO., MD.   |  |  |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE                             |  |  |  |
| Cremation   |  | 12/24/79   |  | Cedar Hill   |  | Suitland Maryland   |  |  |  |
| 24. FUNERAL DIRECTOR NAME   |  |  |  | 25a. DATE REC'D. BY REGISTRAR  |  | 25b. REGISTRAR'S SIGNATURE  |  |  |  |
| Walter Brooks Bradley Inc. Balto., Md.  |  |  |  | DEC 31 1979  |  | <u>[Signature]</u>  |  |  |  |



TO HOSPITAL-ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  |  |  |   |  |   |  |  |  |
|---|--|--|--|--|--|---|--|---|--|--|--|
| 1. FOR STATE REGISTRAR  |  | 7 9 3 0 5 7 6  |  |  |  | REG. NO.  |  |   |  |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |  | FIRST  |  | MIDDLE   |  | LAST  |  | 2a. DATE OF DEATH MONTH DAY YEAR  |  | 2b. HOUR                                     |  |
| Mohammad Sadegh Sadeghi   |  |  |  |  |  |   |  | December 9, 1979  |  | 10:05 PM                                     |  |
| 3 SEX   |  | 4 RACE   |  | 5 DATE OF BIRTH MONTH DAY YEAR   |  | 6 AGE (IN YEARS LAST BIRTHDAY)  |  | 7 IF UNDER 1 YEAR MONTHS DAYS   |  | 8 IF UNDER 24 HRS HOURS MIN                  |  |
| male  |  | white  |  | Oct. 22, 1922  |  | 57 YRS.   |  |   |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH   |  |   |  |  |  |
| Iran  |  | Iran   |  |  |  | Baltimore City MD.  |  |   |  |  |  |
| 10 CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |  |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)   |  | 12b. KIND OF BUSINESS OR INDUSTRY            |  |
| Baltimore   |  | The Johns Hopkins Hospital   |  |  |  |   |  | Banker  |  | Bank   |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  | 13a. STATE   |  | 13b. COUNTY  |  | 13c. CITY OR TOWN   |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |  | 13e. STREET ADDRESS                          |  |
| Maryland  |  | Montgomery   |  | Potomac  |  |   |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 1368 Canterbury Way                          |  |
| 14 FATHER'S NAME FIRST MIDDLE LAST  |  | 15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST  |  |  |  |   |  |   |  |  |  |
| Aboulhassan   |  | Behjat   |  | Adle   |  |   |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)   |  | 16b. SOCIAL SECURITY NO  |  | 17 INFORMANT   |  | ADDRESS   |  |   |  |  |  |
| no  |  | none   |  | Mohammad Saberi  |  | 1368 Canterbury Way Potomac, Maryland   |  |   |  |  |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))   |  |  |  |  |  |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART 1. DEATH WAS CAUSED BY:  |  |  |  |  |  |   |  |   |  | 5 minutes                                    |  |
| IMMEDIATE CAUSE (a) <u>respiratory arrest</u>   |  |  |  |  |  |   |  |   |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF (b) <u>restrictive lung disease</u>  |  |  |  |  |  |   |  |   |  | 1 year                                       |  |
| DUE TO, OR AS A CONSEQUENCE OF (c) <u>amyotrophic lateral sclerosis</u>   |  |  |  |  |  |   |  |   |  | 2 yrs  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:  |  |  |  |  |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |  |
|   |  |  |  |  |  |   |  |   |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |   |  |   |  |  |  |
|   |  | P.M. 19  |  |  |  |   |  |   |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  | 21f. LOCATION STREET   |  | CITY OR TOWN  |  | COUNTY  |  | STATE  |  |
|   |  |  |  |  |  |   |  |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>Dec 9th</u> 19 <u>79</u> to <u>Dec 9th</u> 19 <u>79</u> , that (I) (we) lost <u>saw</u> the deceased <u>glance on</u> above (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |   |  |   |  |  |  |
| 22b. SIGNATURE  |  | DEGREE   |  |  |  | 22c. DATE SIGNED  |  |   |  |  |  |
| <u>Peter Rock</u>   |  | MD   |  |  |  | 12-9-79   |  |   |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  | 22e. ADDRESS   |  |  |  |   |  |   |  |  |  |
| Peter Rock  |  | Baltimore, Maryland  |  |  |  | Johns Hopkins Hospital  |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION CITY OR TOWN  |  | COUNTY  |  | STATE  |  |
| Burial-Transit  |  | 12/15/79   |  | Teheran Cemetery   |  | Teheran   |  | Iran  |  |  |  |
| 24 FUNERAL DIRECTOR   |  | 25a. DATE REC'D. BY REGISTRAR  |  |  |  | 25b. REGISTRAR'S SIGNATURE  |  |   |  |  |  |
| Joseph Gawler's Sons, Inc.  |  | DEC 19 1979  |  |  |  | <u>David H. H. H.</u>   |  |   |  |  |  |
| 5130 Wisconsin Avenue, N. W.  |  | Washington, D. C. 20016  |  |  |  |   |  |   |  |  |  |

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**NAME:** Robert Sample  
**DATE OF DEATH:** Dec. 9, 1979  
**PLACE OF DEATH:** Baltimore City

**SEE:** LATE DECEMBER DEATHS  
#79-32060

DMH 2485 - Vit. Rec.



DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

7 9 30577

1- FOR  
STATE  
REGISTRAR

|  |  |  |   |  |  |   |  |
|--|--|--|---|--|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>DELBERT D. SAMPLES</b>  |  |  | 2a. DATE OF DEATH<br>MONTH <b>12</b> DAY <b>12</b> YEAR <b>79</b> |  |  | 2b. HOUR<br><b>10:45 PM</b>   |  |
| 3. SEX<br><b>Male</b>  |  | 4. RACE<br><b>White</b>  |   | 5. DATE OF BIRTH<br>MONTH <b>4</b> DAY <b>21</b> YEAR <b>13</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>66</b> YRS  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Virginia</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Lutheran Hospital of Md.</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Burner</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Ship Yard</b>   |  |
| 13a. STATE<br><b>md</b>  |  | 13b. COUNTY<br><b>---</b>  |   | 13c. CITY OR TOWN<br><b>Baltimore</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>           |  |
| 14. FATHER'S NAME<br>FIRST <b>Unknown</b> MIDDLE <b>---</b> LAST <b>Samples</b>  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>Pauline</b> MIDDLE <b>---</b> LAST <b>Forbes</b>  |   | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>227 09 7873</b>  |  |
| 17. INFORMANT<br><b>Mary E. McClung</b>  |  | 18. ADDRESS<br><b>3022 Lonera Avenue<br/>Baltimore, Maryland 21230</b>   |   | 19. DATE OF OPERATION<br><b>11-27-1979</b>   |  | 20. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>CARDIAC ARREST</b>                                  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER) |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>---</b> P.M. <b>19</b>   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  | 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> |  |
| 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |   | 22a. I certify that (this hospital) attended the deceased from <b>11-27-1979</b> to <b>12-12-1979</b> , that (we) last saw the deceased alive on <b>12-12-1979</b> , and that in (our) opinion death occurred on the date and hour and from the causes stated above. (we) (did) (not) view the body after death. |  | 22b. SIGNATURE<br><b>Surendra P. Paruchuri</b> DEGREE <b>MD</b>   |  |
| 22c. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>SURENDRA P. PARUCHURI</b>  |  | 22d. ADDRESS<br><b>LUTHERAN HOSP. BAC. MD-21216</b>  |   | 22e. DATE SIGNED<br><b>12-12-79</b>  |  | 22f. DATE RECD. BY REGISTRAR<br><b>DEC 17 1979</b>  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY) <b>Burial</b>   |  | 23b. DATE<br><b>12-15-1979</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Cedar Hill Cemetery</b>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Maryland</b>                                   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>McCurly Funeral Home of Brooklyn Bkto., Md.</b>   |  | 24b. DATE<br><b>12-15-1979</b>   |   | 24c. NAME OF CEMETERY OR CREMATORY<br><b>Cedar Hill Cemetery</b>   |  | 24d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Maryland</b>                                   |  |

MEDICAL CERTIFICATION

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).

PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) **CARDIAC ARREST****4292**

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.

(b) **A. S. C. V. D.**

DUE TO, OR AS A CONSEQUENCE OF

(c) **C. O. P. D., PNEUMONIA**

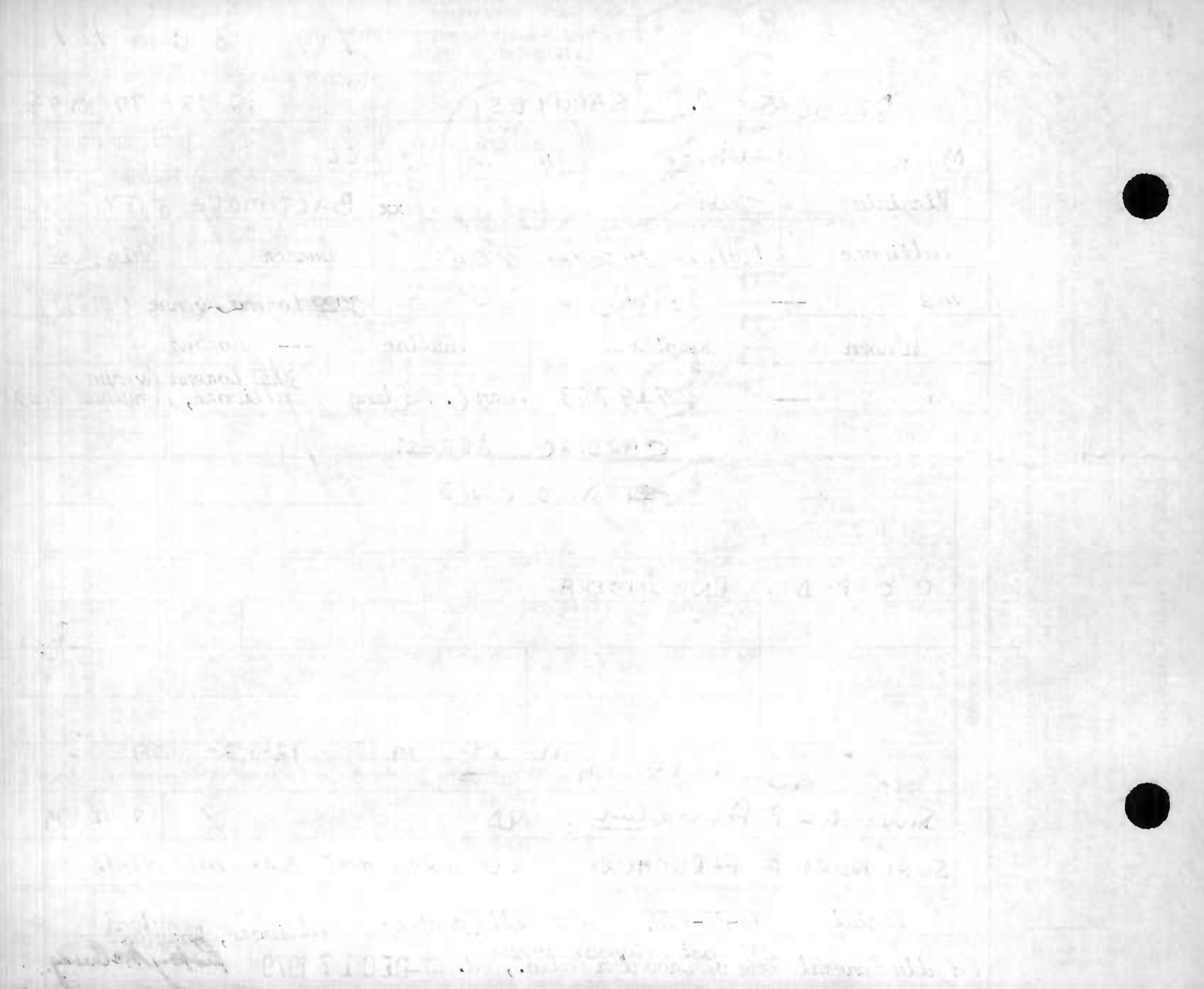
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

**C. O. P. D., PNEUMONIA**APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| FOR<br>STATE<br>REGISTRAR  |   | STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  | 79 30578<br>REG. NO.  |  |
|--|---|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Ina B. Sanders</b>   |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>December 25, 1979</b>   |  | 2b. HOUR<br><b>11:15a M</b>   |  |
| 3. SEX<br><b>Female</b>  | 4. RACE<br><b>White</b>   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>October 27, 1898</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>81</b><br>YRS. MONTHS DAYS                                |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>   | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.                               |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Maryland General Hospital</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Retired</b> |   | 12b. KIND OF BUSINESS OR INDUSTRY  |
| 13a. STATE<br><b>Maryland</b>  |   | 13b. COUNTY<br><b>Baltimore</b>   | 13c. CITY OR TOWN<br><b>Baltimore</b>  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS<br><b>2211 W. Rogers Avenue</b>  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>George A. Buxton</b>  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Jessie M. Baldwin</b>   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>  |   | 16b. SOCIAL SECURITY NO<br><b>217 38 1730</b>   |  | 17. INFORMANT<br>ADDRESS<br><b>Wesley Home, Inc. 2211 W. Rogers Ave, 21209</b>                  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <b>Myocardial Infarction</b><br><b>410-</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |   |   |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____  |   |   |  |   |  |
| 19a. DATE OF OPERATION   |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>December 24, 1979</b> , to <b>December 25, 1979</b> , that (s) (we) last saw the deceased alive on <b>December 25, 1979</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.               |   |   |  |   |  |
| 22b. SIGNATURE<br><b>Kai-Fu Chow</b>   |   | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>        |  | 22c. DATE SIGNED<br><b>12/25/79</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Kai-Fu Chow, M.D.</b>  |   | 22e. ADDRESS<br><b>c/o 827 Linden Ave. Balto. MD 21201</b>  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |   | 23b. DATE<br><b>28 Dec. 1979</b>  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Baltimore Nat'l Cem.</b>                  |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore, Maryland</b>   |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Burgee Funeral Home 3631 Falls Rd. 21211</b>  |   | 25a. DATE REC'D. BY REGISTRAR<br><b>DEC 27 1979</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>History McCreedy</b>   |  |



STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

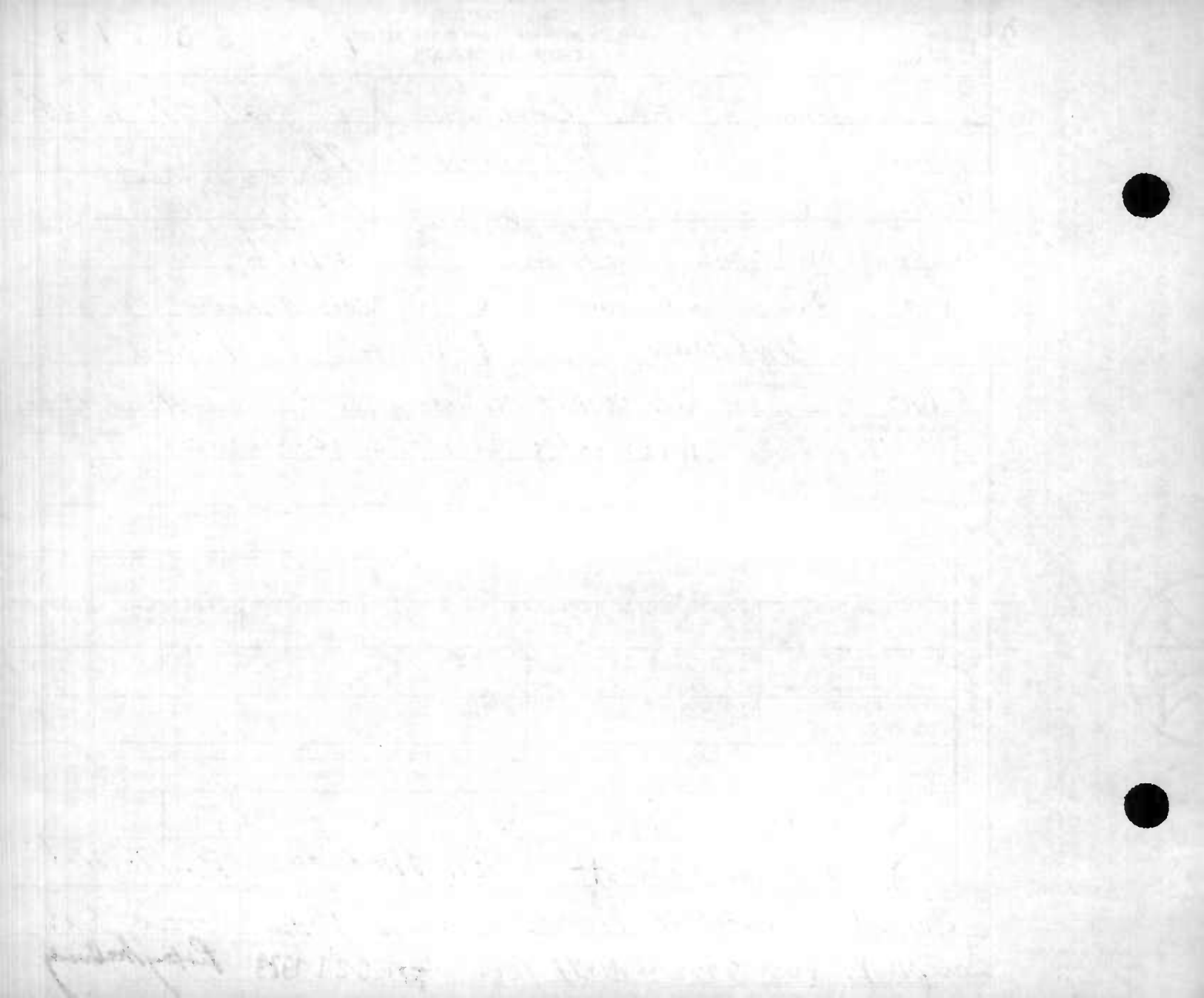
FOR  
1- STATE  
REGISTRAR

|   |   |   |   |  |  |
|---|---|---|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>James F SANDERS  |   |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>12/17/79   |  | 2b. HOUR<br>12:20 AM   |
| 3. SEX<br>male  | 4. RACE<br>Col.   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>1-16-1905   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>74   |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Crestfield, Md.  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTO. City MD.   |  |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore Md.  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Sinas Hospital |   | 12a. USUAL OCCUPATION<br>(TYPE IF WORK FOR MOST OF WORKING LIFE)<br>Retired                     |  | 12b. KIND OF BUSINESS OR INDUSTRY  |
| 13. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |   |   |   |  |  |
| 13a. STATE<br>md  | 13b. COUNTY<br>Baltimore  | 13c. CITY OR TOWN<br>Baltimore  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS<br>2815 Mohawk Ave   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>UNKNOWN   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Rebecca Hillman  |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>NO  |   | 16b. SOCIAL SECURITY NO.<br>29-05-1819  |   | 17. INFORMANT<br>Mr. Pinkney Howell 2815 Mohawk Ave.                           |  |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY.<br>IMMEDIATE CAUSE (a) Metastatic Prostatic Carcinoma<br>185-<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |   |   |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)  |   |   |   |  |  |
| 19a. DATE OF OPERATION  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>      | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |   |   |   |  |  |
| 22b. SIGNATURE<br>D. William Schlott MD   |   | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>        |   | 22c. DATE SIGNED   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>D. William Schlott   |   | 22e. ADDRESS<br>611 Park Ave, BALTO. MD.  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial  |   | 23b. DATE<br>12-23-79   | 23c. NAME OF CEMETERY OR CREMATORY<br>Pleasant Grove Ch. Co.                                    |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Pleasant Grove S.C.  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Joseph L. Russ  |   | ADDRESS<br>2222 W. North Ave.   |   | 25a. DATE REC'D. BY REGISTRAR<br>DEC 21 1979                                   | 25b. REGISTRAR'S SIGNATURE<br>P. H. H. H.  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

7 9 30580

1. FOR  
STATE  
REGISTRAR

REG. NO.

|  |  |  |   |  |  |   |  |  |   |  |  |
|--|--|--|---|--|--|---|--|--|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <i>Jessie</i>                |  |  | FIRST MIDDLE LAST <i>Sanders</i>  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR <i>12 28 79</i>  |  |  | 2b. HOUR <i>130 AM</i>  |  |  |
| 3. SEX<br><i>Female</i>  |  |  | 4. RACE<br><i>Black</i>   |  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR <i>7 4 16</i>  |  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><i>63</i>  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><i>S.C.</i>         |  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><i>USA</i>  |  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><i>BALTIMORE CITY</i> MD.                               |  |  |
| 10. CITY OR TOWN OF DEATH<br><i>Baltimore</i>                    |  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><i>BALTIMORE CITY HOSPITAL</i> |  |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |  |
| 13a. STATE<br><i>Maryland</i>                                    |  |  | 13b. COUNTY   |  |  | 13c. CITY OR TOWN<br><i>Baltimore</i>   |  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><i>LESS GOODSON</i>    |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><i>LILLE BACOTE</i>  |  |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <i>No</i>  |  |  | 16b. SOCIAL SECURITY NO.<br><i>225-20-5101</i>  |  |  |
| 17. INFORMANT<br>ADDRESS<br><i>DOROTHY STEWART Same As Above</i> |  |  |   |  |  |   |  |  |   |  |  |

|  |  |  |  |
|--|--|--|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>SEPSIS</i> |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH                  |  |
| 586-<br>Conditions, if any, which<br>gave rise to immediate<br>cause (a), stating the<br>underlying cause last.                                |  | DUE TO, OR AS A CONSEQUENCE OF<br>(b) <i>PNEUMONIA</i>           |  |
|  |  | DUE TO, OR AS A CONSEQUENCE OF<br>(c) <i>RESPIRATORY FAILURE</i> |  |

|  |  |   |  |
|--|--|---|--|
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |   |  |
| 19a. DATE OF OPERATION<br><i>12/11/79</i>  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><i>Uremic Colitis</i>   |  |
| 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><i>19</i>  |  |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  |
| 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |   |  |
| 22a. I certify that (1) (this hospital) attended the deceased from <i>12/11</i> 19 <i>79</i> to <i>12/28</i> 19 <i>79</i> , that (1) (we) last<br>saw the deceased alive on <i>12/28</i> 19 <i>79</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above (1) (we) (did) (did not) view the body after death. |  |   |  |
| 22b. SIGNATURE<br><i>Kenneth Kern</i>  |  | 22c. DATE SIGNED<br><i>12/28/79</i>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><i>Kenneth Kern</i>   |  | 22e. ADDRESS<br><i>Baltimore City Hospital</i>  |  |

|   |  |                              |  |   |  |   |  |
|---|--|------------------------------|--|---|--|---|--|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><i>Burial</i> |  | 23b. DATE<br><i>12-31-79</i> |  | 23c. NAME OF CEMETERY OR CREMATORY<br><i>MT. CALVARY CEM.</i> |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><i>ANNE ARUNDEL CO. MD.</i> |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><i>Wm. C. March F/H</i>       |  |                              |  | 25. DATE REC'D. BY REGISTRAR<br><i>DEC 31 1979</i>            |  | 25b. REGISTRAR'S SIGNATURE<br><i>Dorothy McCreedy</i>                     |  |
| ADDRESS<br><i>1101 E. North Ave.</i>                          |  |                              |  |   |  |   |  |

1911

THE STATE OF NEW YORK  
IN SENATE  
January 11, 1911.

| NAME           |  | RESIDENCE     |  | EDUCATION              |  | OCCUPATION |  | POLITICAL PARTY |  | DATE OF BIRTH |  | DATE OF DEATH |  |
|----------------|--|---------------|--|------------------------|--|------------|--|-----------------|--|---------------|--|---------------|--|
| J. B. ALLEN    |  | New York City |  | Harvard University     |  | Lawyer     |  | Republican      |  | 1850          |  | 1910          |  |
| W. H. BROWN    |  | Albany        |  | Cornell University     |  | Physician  |  | Republican      |  | 1860          |  | 1905          |  |
| C. D. GREEN    |  | Syracuse      |  | Syracuse University    |  | Teacher    |  | Republican      |  | 1870          |  | 1908          |  |
| E. F. HARRIS   |  | Buffalo       |  | University of Michigan |  | Engineer   |  | Republican      |  | 1865          |  | 1902          |  |
| J. K. LEE      |  | Rochester     |  | Rochester College      |  | Minister   |  | Republican      |  | 1855          |  | 1900          |  |
| M. N. PETERSON |  | Schenectady   |  | Schenectady College    |  | Teacher    |  | Republican      |  | 1875          |  | 1907          |  |
| R. S. SMITH    |  | Watkinsville  |  | Watkinsville College   |  | Farmer     |  | Republican      |  | 1860          |  | 1903          |  |
| T. U. TAYLOR   |  | Utica         |  | Utica College          |  | Lawyer     |  | Republican      |  | 1850          |  | 1900          |  |
| V. W. WALKER   |  | Binghamton    |  | Binghamton College     |  | Teacher    |  | Republican      |  | 1870          |  | 1905          |  |
| X. Y. Z.       |  | New York City |  | Harvard University     |  | Lawyer     |  | Republican      |  | 1850          |  | 1910          |  |

Attest: J. B. ALLEN, Clerk of the Senate.  
J. B. ALLEN, Clerk of the Senate.  
J. B. ALLEN, Clerk of the Senate.

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

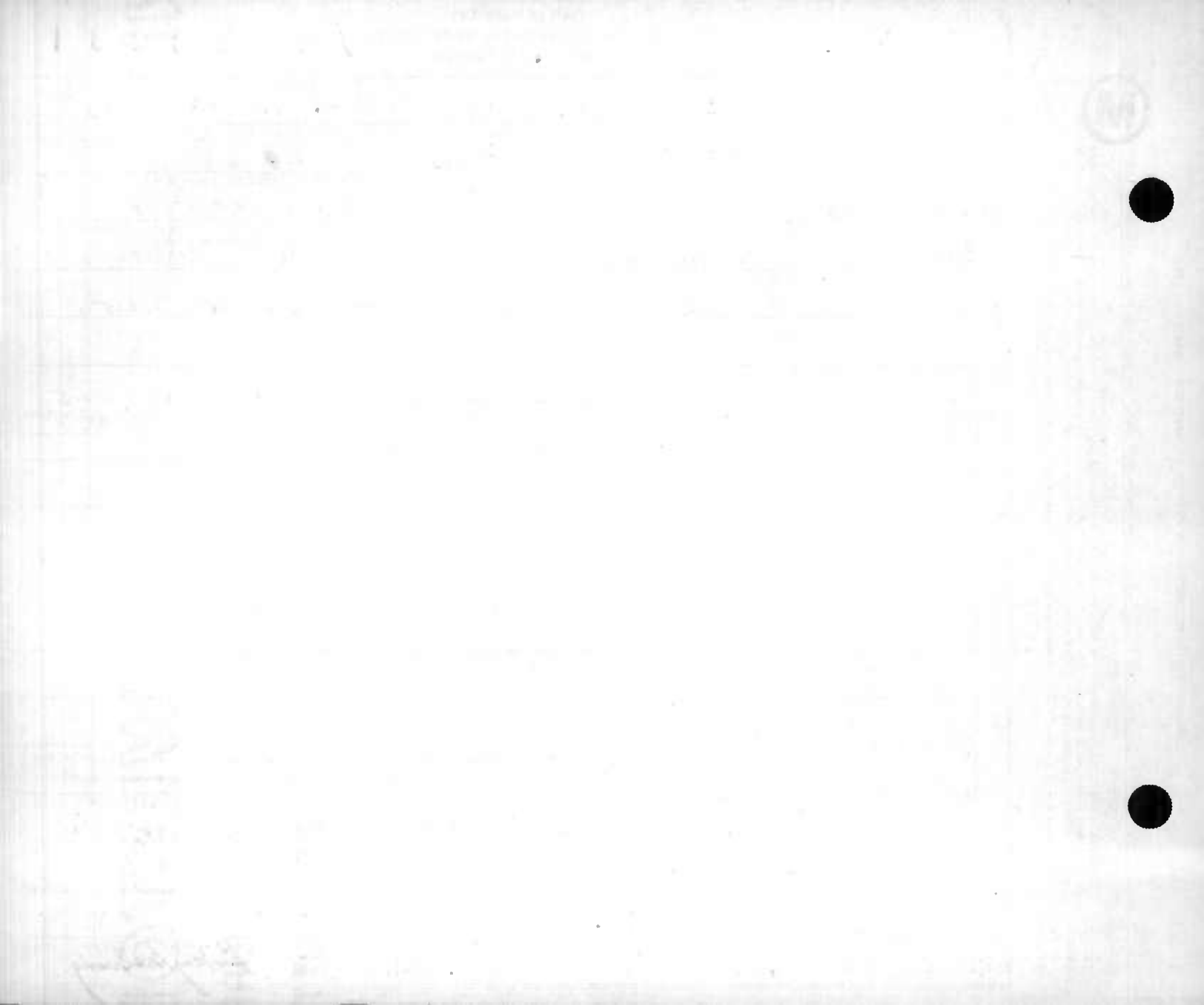
79 30581

REG. NO.

1- FOR  
STATE  
REGISTRAR

|   |  |  |  |   |   |  |   |   |         |  |
|---|--|--|--|---|---|--|---|---|---------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>WILLIE L. SANDERS</b>  |  |  | 2a. DATE OF DEATH<br>MONTH <b>DEC.</b> DAY <b>12</b> YEAR <b>79</b>            |   |   | 2b. HOUR<br><b>12 55 A.M.</b>  |   |   |         |  |
| 3 SEX<br><b>MALE</b>  |  | 4 RACE<br><b>NEGRO</b>   |  | 5 DATE OF BIRTH<br>MONTH <b>12</b> DAY <b>28</b> YEAR <b>1923</b>   |   | 6 AGE (IN YEARS LAST BIRTHDAY)<br><b>56</b> YRS.   |   | 7 IF UNDER 1 YEAR<br>MONTHS <b>0</b> DAYS <b>0</b> HOURS <b>0</b> MIN.  |         |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>NORTH CAROLINA</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.   |   |   |         |  |
| 10 CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>SINAI HOSPITAL</b> |  |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>COOK</b>  |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>WHT. COFFEE POT</b>   |         |  |
| 13a. STATE<br><b>MARYLAND</b>   |  |  | 13b. CITY OR TOWN<br><b>BALTO.</b>   |   | 13c. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13d. STREET ADDRESS<br><b>3346 VIRGINIA AVE. 21215</b>                                      |   |         |  |
| 14. FATHER'S NAME<br>FIRST <b>350</b> MIDDLE <b>350</b> LAST <b>350</b>   |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>350</b> MIDDLE <b>350</b> LAST <b>350</b> |   |   |  |   |   |         |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>NO</b>  |  |  | 16b. SOCIAL SECURITY NO.<br><b>237-30-2838</b>                                 |   | 17 INFORMANT<br><b>JANTHA SANDERS/3401 DUPONT AVE. 21215</b>                                    |  |   |   | ADDRESS |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for 1a), 1b), and 1c):<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>1733 INVASIVE SQUAMOUS CELL CA OF FACE</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____   |  |  |  |   |   |  |   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH   |         |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a)  |  |  |  |   |   |  |   |   |         |  |
| 19a. DATE OF OPERATION  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                               |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |   | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |         |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. <b>19</b>              |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                  |  |   |   |         |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)         |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |   |         |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>12/19</b> , 19 <b>79</b> , to <b>12/29</b> , 19 <b>79</b> , that (I) (we) last saw the deceased alive on <b>12/29</b> , 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |   |   |  |   |   |         |  |
| 22b. SIGNATURE<br><b>Robert A. Wacks</b>  |  |  | DEGREE<br><b>M.D.</b>  |   |   | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |   | 22c. DATE SIGNED<br><b>12/29/79</b>   |         |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Robert A. Wacks</b>   |  |  | 22e. ADDRESS<br><b>Sinai Hosp at Balt.</b>                                     |   |   |  |   |   |         |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY) <b>BURIAL</b>  |  |  | 23b. DATE<br><b>01/04/80</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>MT. CALVARY CEM</b>                                    |  | 23d. LOCATION<br>CITY OR TOWN <b>BALTIMORE</b> COUNTY <b>MARYLAND</b> STATE <b>MARYLAND</b> |   |         |  |
| 24 FUNERAL DIRECTOR<br>NAME <b>MARSHALL W JONES, JR/4101 EDMONDSON AVE.</b> ADDRESS   |  |  |  |   | 25a. DATE REC'D. BY REGISTRAR<br><b>JAN 7 1980</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>Anthony McRuddy</b>  |   |         |  |







TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 3. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED IN THE DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP  
DHMH - 17  
(VR A15 ME (5))  
15M 7/76

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 30582

|  |  |  |  |   |  |   |  |   |  |                  |  |                                      |  |   |  |          |  |      |  |  |  |
|--|--|--|--|---|--|---|--|---|--|------------------|--|--------------------------------------|--|---|--|----------|--|------|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  | FIRST  |  | MIDDLE  |  | LAST  |  | 2a. DATE KNOWN OF DEATH   |  | MONTH            |  | DAY                                  |  | YEAR  |  | 2b. HOUR |  |      |  |  |  |
| MICHAEL  |  | Joseph   |  | SANFORD   |  |   |  | 12-27   |  | 19               |  | 79                                   |  |   |  | 6:07     |  |      |  |  |  |
| 3. SEX   |  | 4. RACE  |  | 5. DATE OF BIRTH  |  | 6. AGE (IN YEARS)   |  | IF UNDER 1 YR.  |  | IF UNDER 24 HRS. |  | 7c. DATE PRONOUNCED DEAD             |  | MONTH   |  | DAY      |  | YEAR |  |  |  |
| male   |  | white  |  | SEPT 28 '57   |  | 22 YRS.   |  |   |  |                  |  | 12 -27                               |  | 19  |  | 79       |  | a    |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  | 7b. CITIZEN OF WHAT COUNTRY?                             |  | 8. MARRIED  |  | NEVER MARRIED   |  | WIDOWED   |  | DIVORCED         |  | 9. BALTIMORE CITY OR COUNTY OF DEATH |  |   |  |          |  |      |  |  |  |
| WashingtonDC   |  | U.S.A.   |  |   |  |   |  |   |  |                  |  | Baltimore City                       |  |   |  |          |  |      |  |  |  |
| 10. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) |  | 12b. KIND OF BUSINESS OR INDUSTRY                                   |  |   |  |                  |  |                                      |  |   |  |          |  |      |  |  |  |
| Baltimore  |  | S.I.U. University Hospital                               |  | Student   |  | A.A.Com.Col   |  |   |  |                  |  |                                      |  |   |  |          |  |      |  |  |  |
| 13a. STATE   |  | 13b. COUNTY  |  | 13c. CITY OR TOWN   |  | 13d. INSIDE CITY LIMITS?  |  | 13e. STREET ADDRESS   |  |                  |  |                                      |  |   |  |          |  |      |  |  |  |
| Maryland   |  | Anne Arundel   |  | GlenBurnie  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 809 Bentwillow Drive  |  |                  |  |                                      |  |   |  |          |  |      |  |  |  |
| 14. FATHER'S NAME  |  | 15. MOTHER'S MAIDEN NAME                                 |  |   |  |   |  |   |  |                  |  |                                      |  |   |  |          |  |      |  |  |  |
| FIRST  |  | MIDDLE   |  | LAST  |  | FIRST   |  | MIDDLE  |  | LAST             |  |                                      |  |   |  |          |  |      |  |  |  |
| William  |  | E.   |  | Sanford   |  | Delores   |  | J.  |  | Orem             |  |                                      |  |   |  |          |  |      |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)   |  | 16b. SOCIAL SECURITY NO.                                 |  | 17. INFORMANT   |  | ADDRESS   |  |   |  |                  |  |                                      |  |   |  |          |  |      |  |  |  |
| NO   |  | N/A  |  | 216-28-1885   |  | Mrs. Delores J. Sanford (Mother)                                    |  | Same as # 13  |  |                  |  |                                      |  |   |  |          |  |      |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |  |  |  |   |  |   |  |   |  |                  |  |                                      |  |   |  |          |  |      |  |  |  |
| PART I DEATH WAS CAUSED BY: Multiple injuries  |  |  |  |   |  |   |  |   |  |                  |  |                                      |  |   |  |          |  |      |  |  |  |
| IMMEDIATE CAUSE (a) 8120   |  |  |  |   |  |   |  |   |  |                  |  |                                      |  |   |  |          |  |      |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF   |  |  |  |   |  |   |  |   |  |                  |  |                                      |  |   |  |          |  |      |  |  |  |
| Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.  |  |  |  |   |  |   |  |   |  |                  |  |                                      |  |   |  |          |  |      |  |  |  |
| (b)  |  |  |  |   |  |   |  |   |  |                  |  |                                      |  |   |  |          |  |      |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF   |  |  |  |   |  |   |  |   |  |                  |  |                                      |  |   |  |          |  |      |  |  |  |
| (c)  |  |  |  |   |  |   |  |   |  |                  |  |                                      |  |   |  |          |  |      |  |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).  |  |  |  |   |  |   |  |   |  |                  |  |                                      |  |   |  |          |  |      |  |  |  |
| 19a. DATE OF OPERATION   |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?             |  |   |  |   |  |                  |  |                                      |  | 20. AUTOPSY?  |  |          |  |      |  |  |  |
|  |  |  |  |   |  |   |  |   |  |                  |  |                                      |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |          |  |      |  |  |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |  |  |  | 21b. TIME OF INJURY   |  |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) |  |                  |  |                                      |  |   |  |          |  |      |  |  |  |
|  |  |  |  | 4:05 PM 12-27 1979  |  |   |  | driver of auto/auto headon collision  |  |                  |  |                                      |  |   |  |          |  |      |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK  |  |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)   |  |   |  | 21f. LOCATION   |  |                  |  |                                      |  |   |  |          |  |      |  |  |  |
|  |  |  |  | highway   |  |   |  | GermanhillRd&840 W. of Aldsworth Ave. Balto., Co.                             |  |                  |  |                                      |  |   |  |          |  |      |  |  |  |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |  |  |  |   |  |   |  |   |  |                  |  |                                      |  |   |  |          |  |      |  |  |  |
| ACTUAL SIGNATURE   |  |  |  | TITLE (SPECIFY)   |  |   |  | DATE SIGNED   |  |                  |  |                                      |  |   |  |          |  |      |  |  |  |
| Margarita A. Korell, M.D.  |  |  |  | Assistant   |  |   |  | 12/27/79  |  |                  |  |                                      |  |   |  |          |  |      |  |  |  |
| EXAMINER'S NAME (TYPE OR PRINT)  |  |  |  | ADDRESS   |  |   |  |   |  |                  |  |                                      |  |   |  |          |  |      |  |  |  |
| Margarita A. Korell, M.D.  |  |  |  | 111 Penn Street   |  |   |  |   |  |                  |  |                                      |  |   |  |          |  |      |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |  |  |  | 23b. DATE   |  |   |  | 23c. NAME OF CEMETERY OR CREMATORY  |  |                  |  | 23d. LOCATION                        |  |   |  |          |  |      |  |  |  |
| Burial   |  |  |  | 31 DEC '79  |  |   |  | Meadowridge Mem.Pk.   |  |                  |  | Elkridge                             |  |   |  |          |  |      |  |  |  |
| 24. FUNERAL DIRECTOR   |  |  |  | 25a. DATE REC'D. BY REGISTRAR                                 |  |   |  | 25b. REC'D. BY REGISTRAR  |  |                  |  |                                      |  |   |  |          |  |      |  |  |  |
| SINGLETON FUNERAL HOME, GLEN BURNIE, MD.   |  |  |  | DEC 28 1979   |  |   |  | Howard Md.  |  |                  |  |                                      |  |   |  |          |  |      |  |  |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |                 |  |   |  |   |
|---|-----------------|--|---|--|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>ROSE L SANSONE  |                 |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>12-05-1979 |  | 2b. HOUR<br>8.15 AM                             |
| 3 SEX<br>FEMALE   | 4 RACE<br>WHITE | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>06 09 04   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>75 YRS.   |   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Italy  |                 | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD                            |   |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE  |                 | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>ST AGNES HOSPITAL |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Housewife        |   |
| 12b. KIND OF BUSINESS OR INDUSTRY   |                 |  |   |  |   |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |                 |  |   |  |   |
| 13a. STATE<br>Maryland  |                 | 13b. COUNTY<br>Baltimore   |   | 13c. CITY OR TOWN<br>Catonsville   |   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>John Battista Lucido  |                 | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Rose Presti   |   |  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>no  |                 | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>220-14-5795   |   | 17. INFORMANT<br>ADDRESS<br>Marie S. Serio, 6112 Wheatland Rd. 21228                 |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Metastatic carcinoma both lungs<br>1588<br>DOE TO, OR AS A CONSEQUENCE OF<br>(b) Adenocarcinoma Rt lung<br>DOE TO, OR AS A CONSEQUENCE OF<br>(c) Adenocarcinoma Abdominal Omentum     |                 |  |   |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)   |                 |  |   |  |   |
| 19a. DATE OF OPERATION  |                 | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |                 | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)       |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |                 | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |   |
| 22a. I certify that (I) (this hospital) attended the deceased from June 19 79, to 12-5 19 79, that (I) (we) lost<br>saw the deceased alive on 12-4 19 79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death. |                 |  |   |  |   |
| 22b. SIGNATURE<br>Joseph N. Miller, MD  |                 | DEGREE   |   | 22c. DATE SIGNED<br>12-5-79  |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>JOSEPH H. Miller, MD   |                 | 22e. ADDRESS<br>900 CATON AVE. BALTIMORE, MD. 21229  |   |  |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial  |                 | 23b. DATE<br>2/6/79  |   | 23c. NAME OF CEMETERY OR CREMATORY<br>New Cathedral Cem.                             |   |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore, Maryland   |                 |  |   |  |   |
| 24. FUNERAL DIRECTOR 1630 Edmondson Ave. Catonsville Md<br>NAME ADDRESS<br>Witzke Funeral Home of Catonsville, P.A. 21228   |                 |  |   | 25a. DATE REC'D. BY REGISTRAR<br>DEC 7 1979  |   |
|   |                 |  |   | 25b. REGISTRAR'S SIGNATURE<br>Petrysky   |   |

BP

200 CATON AVE. BALTIMORE, MD. 11000

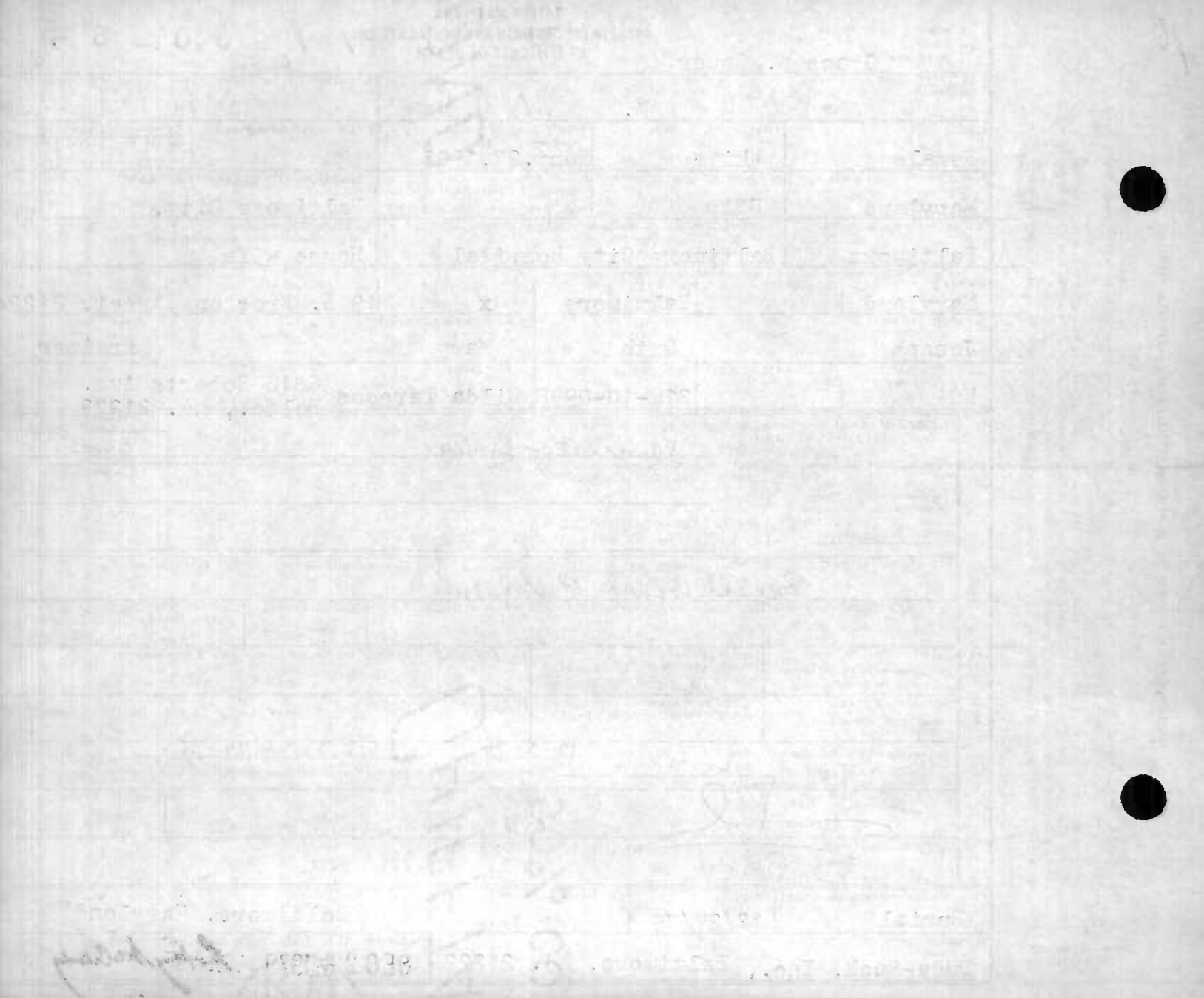
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  |  |  | 7 9 3 0 5 8 4  |  |  |  |
|--|--|--|--|--|--|--|--|
| 1- FOR STATE REGISTRAR Grace M. Sauer  |  |  |  | CERTIFICATE OF DEATH   |  |  |  |
| 1. DECEASED NAME (TYPE OR PRINT)   |  |  |  | 2a. DATE OF DEATH  |  |  |  |
| FIRST MIDDLE LAST  |  |  |  | MONTH DAY YEAR   |  |  |  |
| GRACE M. SAUER   |  |  |  | 12 24 79   |  |  |  |
| 3. SEX   |  | 4. RACE  |  | 5. DATE OF BIRTH   |  | 6. AGE (IN YEARS LAST BIRTHDAY)                                |  |
| Female   |  | White  |  | MONTH DAY YEAR   |  | 74 YRS.  |  |
| Sept. 27, 1905   |  |  |  |  |  |  |  |
| 7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                           |  |
| Maryland   |  | USA  |  |  |  | Baltimore City, MD.  |  |
| 10. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |  | 12b. KIND OF BUSINESS OR INDUSTRY                              |  |
| Baltimore  |  | Baltimore City Hospital  |  | House wife   |  |  |  |
| 13a. STATE   |  |  |  | 13b. COUNTY  |  |  |  |
| Maryland   |  |  |  | Baltimore  |  |  |  |
| 13c. CITY OR TOWN  |  |  |  | 13d. INSIDE CITY LIMITS?   |  |  |  |
| Baltimore  |  |  |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  |  |  |
| 14. FATHER'S NAME  |  |  |  | 15. MOTHER'S MAIDEN NAME   |  |  |  |
| FIRST MIDDLE LAST  |  |  |  | FIRST MIDDLE LAST  |  |  |  |
| Joseph Orth  |  |  |  | Mary Kreiner   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)  |  |  |  | 16b. SOCIAL SECURITY NO.   |  |  |  |
| NO   |  |  |  | 216-10-0998  |  |  |  |
| 17. INFORMANT  |  |  |  | ADDRESS  |  |  |  |
| Hilda Parsons  |  |  |  | 6816 Roberts Ave. Balto., Md. 21222  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |  |  |
| IMMEDIATE CAUSE (a) <u>Pancreatic Cancer</u>   |  |  |  | 3 yrs.   |  |  |  |
| 1579   |  |  |  |  |  |  |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last  |  |  |  |  |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF   |  |  |  |  |  |  |  |
| (b)  |  |  |  |  |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF   |  |  |  |  |  |  |  |
| (c)  |  |  |  |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |  |  |  |  |  |  |
| <u>Small Bowel Obstruction</u>   |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |  |
|  |  |  |  | YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | YES <input type="checkbox"/> NO <input type="checkbox"/>       |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |  |  |
|  |  | HOUR A.M. MONTH DAY YEAR   |  |  |  |  |  |
|  |  | P.M. 19  |  |  |  |  |  |
| 21d. INJURY OCCURRED   |  | 21e. PLACE OF INJURY   |  | 21f. LOCATION  |  |  |  |
| WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | STREET CITY OR TOWN COUNTY STATE   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>12-3-79</u> , 19____, to <u>12-24-79</u> , 19____, that (I) (we) last saw the deceased alive on <u>12-24-79</u> , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |  |  |
| 22b. SIGNATURE   |  |  |  | DEGREE   |  | 22c. DATE SIGNED   |  |
| <u>[Signature]</u>   |  |  |  | MD ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                       |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  |  |  | 22e. ADDRESS   |  |  |  |
| D. PAREY   |  |  |  | Baltimore  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION  |  |
| Burial   |  | 12/27/79   |  | Oak Lawn   |  | Baltimore, Maryland  |  |
| 24. FUNERAL DIRECTOR   |  |  |  | 25a. DATE REC'D. BY REGISTRAR  |  |  |  |
| NAME ADDRESS   |  |  |  | 25b. REGISTRAR'S SIGNATURE   |  |  |  |
| Duda-Ruck, Inc., Baltimore, Md. 21222  |  |  |  | DEC 26 1979 <u>[Signature]</u>   |  |  |  |





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| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  |   |  |  |  |  |  | 79  |  | 30585 |  |
|---|--|--|--|---|--|--|--|--|--|---|--|-------|--|
| FOR<br>1- STATE<br>REGISTRAR  |  |  |  | REG. NO.  |  |  |  |  |  |   |  |       |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Lloyd E. Saylor MD</b>   |  |  |  | 2a. DATE OF DEATH<br>MONTH <b>12</b> DAY <b>27</b> YEAR <b>79</b>   |  |  |  | 2b. HOUR<br><b>2225</b>  |  |   |  |       |  |
| 3. SEX<br><b>Male</b>   |  | 4. RACE<br><b>Cauc.</b>  |  | 5. DATE OF BIRTH<br>MONTH <b>5</b> DAY <b>12</b> YEAR <b>06</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>73</b>   |  | IF UNDER 1 YEAR<br>MONTHS <b></b> DAYS <b></b>   |  | IF UNDER 24 HRS<br>HOURS <b></b> MIN <b></b>  |  |       |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Pa.</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b>                        |  |  |  | MD  |  |       |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>University of Md. S.T.U.</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Doctor</b>    |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>MEDICAL</b>  |  |   |  |       |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  |  |  | 13e. STREET ADDRESS<br><b>328 BROXTON Rd.</b>  |  |   |  |       |  |
| 13a. STATE<br><b>MD.</b>  |  | 13b. COUNTY<br><b>Balto.</b>   |  | 13c. CITY OR TOWN<br><b>Balto.</b>  |  |  |  |  |  |   |  |       |  |
| 14. FATHER'S NAME<br>FIRST <b>Ward</b> MIDDLE <b></b> LAST <b>Saylor</b>  |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>MARY</b> MIDDLE <b></b> LAST <b>Woy</b>  |  |  |  |  |  |   |  |       |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, GIVE WAR OR DATES)<br><b>YES</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>WWIT 212-01-5558</b>  |  | 17. INFORMANT<br><b>Ruth P. Saylor</b>  |  |  |  | ADDRESS<br><b>Same</b>   |  |   |  |       |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>cardiorespiratory collapse</u><br>DUE TO, OR AS A CONSEQUENCE OF (b) <u>acute myocardial infarction</u><br>DUE TO, OR AS A CONSEQUENCE OF (c) <u>head trauma</u>                                   |  |  |  |   |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>20 min</b><br><b>2 hrs</b><br><b>3 hrs</b> |  |       |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |  |  |   |  |  |  |  |  |   |  |       |  |
| 19a. DATE OF OPERATION<br><b>12/26/79</b>   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>Operative repair of a subarachnoid hemorrhage</b>                                     |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |   |  |       |  |
| 21a. ACCIDENT WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR <b>8:00</b> P.M. MONTH <b>12</b> DAY <b>25</b> YEAR <b>79</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)<br><b>Fell down stairs - Accident</b>  |  |  |  |  |  |   |  |       |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)<br><b>home</b>  |  | 21f. LOCATION<br>STREET <b>328 Broxton Rd.</b> CITY OR TOWN <b>BALTO</b> COUNTY <b>Md</b> STATE <b>Md</b>   |  |  |  |  |  |   |  |       |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>12/27/79</b> to <b>12/27/79</b> , that (I) (we) lost<br>saw the deceased alive on <b>12/27/79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death. |  |  |  |   |  |  |  |  |  |   |  |       |  |
| 22b. SIGNATURE<br><b>Alon S. Davis</b>  |  |  |  | DEGREE<br><b>MD</b>   |  |  |  | 22c. DATE SIGNED<br><b>12/27/79</b>  |  |   |  |       |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Alon S. Davis M.D.</b>  |  |  |  | 22e. ADDRESS<br><b>Dept of Surg; University Hospital</b>  |  |  |  |  |  |   |  |       |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>12/31/79</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Vernon Meth. Ch.</b>   |  |  |  | 23d. LOCATION<br>CITY OR TOWN <b>White Hall</b> COUNTY <b>Md</b> STATE <b>Md</b>   |  |   |  |       |  |
| 24. FUNERAL DIRECTOR<br>NAME <b>Henry W. Jenkins &amp; Sons Co.</b><br>ADDRESS <b>4905 York Road Balto., Md. 21212</b>  |  |  |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>DEC 31 1979</b>                                  |  | 25b. REGISTRAR'S SIGNATURE<br><b>Robert M. Brady</b>   |  |   |  |       |  |



*[Faint, mostly illegible handwritten text across the page, possibly bleed-through from the reverse side.]*



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  |  |  |   |  |   |  |  |  |
|---|--|---|--|--|--|---|--|---|--|--|--|
| 1. FOR STATE REGISTRAR  |  | 7 9 3 0 5 8 6   |  |  |  | REG. NO.  |  |   |  |  |  |
| 1 DECEASED NAME (TYPE OR PRINT)   |  | FIRST   |  | MIDDLE   |  | LAST  |  | 2a. DATE OF DEATH MONTH DAY YEAR  |  | 2b. HOUR                                     |  |
| Gladys F. SCHAUMAN  |  |   |  |  |  |   |  | DECEMBER 26 1979  |  | 11:30 AM                                     |  |
| 3 SEX   |  | 4 RACE  |  | 5 DATE OF BIRTH MONTH DAY YEAR   |  | 6 AGE (IN YEARS LAST BIRTHDAY)  |  | 7a. IF UNDER 1 YEAR MONTHS DAYS   |  | 7b. IF UNDER 24 HRS HOURS MIN.               |  |
| Female  |  | White   |  | Jan. 23 1889   |  | 90 YRS.   |  |   |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  | 7b. CITIZEN OF WHAT COUNTRY?  |  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>                      |  | 9 BALTIMORE CITY OR COUNTY OF DEATH   |  |   |  |  |  |
| Md.   |  | U.S.A.  |  |  |  | Baltimore City MD.  |  |   |  |  |  |
| 10 CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE RESIDENCE ADDRESS) |  |  |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)   |  | 12b. KIND OF BUSINESS OR INDUSTRY            |  |
| Baltimore   |  | 4401 Roland Ave. Apt. #211  |  |  |  |   |  | Housewife   |  | Own Home                                     |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |   |  | 13a. CITY OR TOWN  |  | 13b. INSIDE CITY LIMITS?  |  | 13c. STREET ADDRESS   |  |  |  |
| 13a. STATE  |  |   |  | 13b. COUNTY  |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>               |  | 4401 Roland Ave. Apt. 211   |  |  |  |
| Maryland  |  |   |  | Baltimore  |  |   |  |   |  |  |  |
| 14 FATHER'S NAME FIRST MIDDLE LAST  |  |   |  | 15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST  |  |   |  |   |  |  |  |
| Henry Fenge   |  |   |  | Rosa Blessing  |  |   |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) IF YES, GIVE WAR OR DATES   |  |   |  | 16b. SOCIAL SECURITY NO.   |  | 17 INFORMANT ADDRESS  |  |   |  |  |  |
| No  |  |   |  | 216 46 5738  |  | Mis Janice B. Tiernan Same  |  |   |  |  |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arterio Sclerotic Cardio Vascular Disease</u>   |  |   |  |  |  |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| 4392 DUE TO, OR AS A CONSEQUENCE OF (b) _____   |  |   |  |  |  |   |  |   |  |  |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (c) _____   |  |   |  |  |  |   |  |   |  |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)  |  |   |  |  |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |   |  |   |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                       |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |   |  |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. |  |   |  |  |  |   |  |   |  |  |  |
| 22b. SIGNATURE <u>Thomas L. Worsley MD</u>  |  |   |  | DEGREE <u>FOR DR LLOYD SAYLOR</u> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  |   |  | 22c. DATE SIGNED <u>12/27/79</u>  |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Dr. Thomas L. Worsley, M.D.</u>  |  |   |  | 22e. ADDRESS <u>6505 York Road Balto., Md.</u>   |  |   |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   |  | 23b. DATE   |  | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION CITY OR TOWN  |  | COUNTY  |  | STATE  |  |
| Cremation   |  | 12/28/79  |  | Greenmount   |  | Baltimore   |  |   |  | Md.  |  |
| 24 FUNERAL DIRECTOR NAME <u>Henry W. Jenkins &amp; Sons Co.</u> ADDRESS <u>4905 York Road Balto., Md. 21212</u>   |  |   |  | 25a. DATE REC'D. BY REGISTRAR  |  | 25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>                                     |  |   |  |  |  |
|   |  |   |  | DEC 27 1979  |  |   |  |   |  |  |  |



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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1- FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

30587

|  |  |  |   |  |   |  |   |  |   |  |
|--|--|--|---|--|---|--|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Mary E. SCHINDHELM  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>December 20, 1979                |  |   | 2b. HOUR<br>10:00 PM   |   |  |   |  |
| 3 SEX<br>Female  |  | 4 RACE<br>White  |   | 5 DATE OF BIRTH<br>MONTH DAY YEAR<br>April 16, 1898  |   | 6 AGE (IN YEARS LAST BIRTHDAY)<br>81 YRS.  |   | 7. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.   |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  |   | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9 BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.  |   |  |   |  |
| 10 CITY OR TOWN OF DEATH<br>Baltimore  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>1504 Kennewick Road |   |  |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Homemaker  |   | 12b. KIND OF BUSINESS OR INDUSTRY<br>Own Home  |   |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>Maryland   |  |  | 13b. COUNTY   |  | 13c. CITY OR TOWN<br>Baltimore                          |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br>1504 Kennewick Road            |  |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br>H. Hammen   |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Madgalena Hartmen      |  |   |  |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No   |  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>214 20 53100 |  | 17 INFORMANT<br>ADDRESS<br>Miss Alma M. Schindhelm Same |  |   |  |   |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY.<br>IMMEDIATE CAUSE (a) <u>Acute myocardial infarction</u><br>410-<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>arteriosclerosis</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u></u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |  |   |  |   |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>5 minutes  |   |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |  |   |  |   |  |   |  |   |  |
| 19a. DATE OF OPERATION   |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                        |  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19              |  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |   |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |   |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>Oct 19, 1979</u> , to <u>Oct 19, 1979</u> , that (I) (we) last saw the deceased alive on <u>Oct 19, 1979</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.  |  |  |   |  |   |  |   |  |   |  |
| 22b. SIGNATURE<br><u>Dr. Joseph F. Palmisano</u>   |  |  | DEGREE  |  |   | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |   | 22c. DATE SIGNED<br>12-21-79   |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Dr. Joseph F. Palmisano, M.D.   |  |  | 22e. ADDRESS<br>6608 Loch Raven Blvd. Balto., Md.                       |  |   |  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial  |  |  | 23b. DATE<br>12/24/79   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Sacred Heart      |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Balto. County, Md.                                |  |   |  |
| 24 FUNERAL DIRECTOR<br>NAME<br>Henry W. Jenkins & Sons Co.   |  |  | 24b. ADDRESS<br>4905 York Road Balto., Md.                              |  | 24c. PHONE NO.<br>21212                                 |  | 25a. DATE REC'D. BY REGISTRAR<br>DEC 21 1979  |  | 25b. REGISTRAR'S SIGNATURE<br><u>Barbara McCreedy</u> |  |

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  |   |  |   |  |  |  | 7 9 3 0 5 8 8<br>REG. NO.  |  |  |  |
|--|--|---|--|---|--|---|--|--|--|--|--|--|--|
| 1. FOR STATE REGISTRAR   |  | 1. DECEASED NAME (TYPE OR PRINT)<br>ANNIE Ruth SCHMIDT  |  |   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>12 04 79   |  |  |  | 2b. HOUR<br>9:05 P.M.  |  |  |  |
| 3. SEX<br>Female   |  | 4. RACE<br>White  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>November 4 08   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>71 YRS.  |  | IF UNDER 1 YEAR<br>MONTHS DAYS   |  | IF UNDER 24 HRS<br>HOURS MIN.  |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD.  |  |  |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>South Baltimore General Hospital |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Housewife                          |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Own Home  |  |  |  |  |  |
| 13a. STATE<br>Maryland   |  |   |  | 13b. COUNTY<br>Anne Arundel   |  | 13c. CITY OR TOWN<br>Baltimore  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 13e. STREET ADDRESS<br>408 Doris Avenue Balto., Md. 21225  |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Unknown  |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Unknown  |  |   |  |  |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>NO  |  |   |  | 16b. SOCIAL SECURITY NO.<br>215-32-9939   |  | 17. INFORMANT<br>ADDRESS<br>Baltimore, Maryland 21225<br>Mr. Jacob R. Schmidt, Sr. 408 Doris Avenue |  |  |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1 DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) SEPSIS<br>1890<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) U.T. 9<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |   |  |   |  |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br>Clear cell Ca (? Renal) + mets to lungs  |  |   |  |   |  |   |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  |   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                      |  |  |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 11/27 1979 to 12/4 1979, that (I) (we) last saw the deceased alive on 12/4 1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                             |  |   |  |   |  |   |  |  |  |  |  |  |  |
| 22b. SIGNATURE<br>N. Bhushan   |  |   |  | DEGREE  |  |   |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br>12/04/79   |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>N. BHUSHAN  |  |   |  | 22e. ADDRESS<br>SOUTH BALT. GEN HOSP.   |  |   |  |  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial  |  |   |  | 23b. DATE<br>12/7/79  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Glen Haven Memorial   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Glen Burnie Anne Arundel Md.   |  |  |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Mc Cully Funeral Home of Brooklyn  |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br>DEC 11 1979  |  |   |  | 25b. REGISTRAR'S SIGNATURE<br>T. J. McCrady  |  |  |  |  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death and may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of same.

| FOR STATE REGISTRAR   |  |  |  | STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  | 7 9 3 0 5 8 9<br>REG. NO.   |  |  |  |
|---|--|--|--|--|--|--|--|---|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT)<br><b>CHRISTIAN F SCHMIDT</b>  |  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>DEC 29 1979</b>   |  |  |  | 2b. HOUR<br><b>M</b>  |  |  |  |
| 3. SEX<br><b>M</b>  |  | 4. RACE<br><b>W</b>  |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>DEC 24 1898</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>81</b>                                   |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS<br><b>81</b>  |  | 8. IF UNDER 24 HRS<br>HOURS MIN<br><b>81</b>   |  |
| 9a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MD</b>  |  | 9b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 10. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 11. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTO CITY</b>                     |  |   |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>GERMAN OLD AGE HOME</b> |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>AGENT</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>RAILWAY EXPRESS</b>                    |  |   |  |  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>MD</b>   |  |  |  | 13b. COUNTY<br><b>BALTO</b>  |  | 13c. CITY OR TOWN<br><b>PARKVILLE</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>2410 HARROW AVE</b>  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>FREDERICK SCHMIDT</b>  |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>EMELIE STALK</b>   |  |  |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br><b>NO</b>  |  |  |  | 16b. SOCIAL SECURITY NO.<br><b>514-05-6894</b>   |  | 17. INFORMANT<br><b>FAMILY RECORDS</b>   |  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiac arrhythmia</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>Chronic heart failure</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>Arteriosclerotic heart disease</b><br>CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST<br><b>4140</b> |  |  |  |  |  |  |  |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):  |  |  |  |  |  |  |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |  |   |  |  |  |
| 22. I certify that (I) (this hospital) attended the deceased from <b>Dec 29 1979</b> to <b>Dec 29 1979</b> , that (I) (we) lost saw the deceased alive on <b>29 Dec 1979</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |  |  |  |  |  |  |   |  |  |  |
| 22b. SIGNATURE<br><b>William J. Bryson MD</b>   |  |  |  | 22c. DATE SIGNED<br><b>3 Jan 80</b>  |  |  |  | 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>William BRYSON MD</b>                               |  |  |  |
| 22e. ADDRESS<br><b>5772 WESTVIEW MAIL</b>   |  |  |  | 22f. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>              |  |  |  | 22g. ADDRESS<br><b>5772 WESTVIEW MAIL</b>   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>BURIAL</b>  |  |  |  | 23b. DATE<br><b>1-2-80</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>MORRISLAND MEM PK</b>                 |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>BALTO CO MD</b>                                |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>EVANS FUNERAL CHAPEL</b>   |  |  |  |  |  | 24b. ADDRESS<br><b>8800 HARTFORD RD</b>  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JAN 3 1980</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>L. J. McBrady</b>   |  |





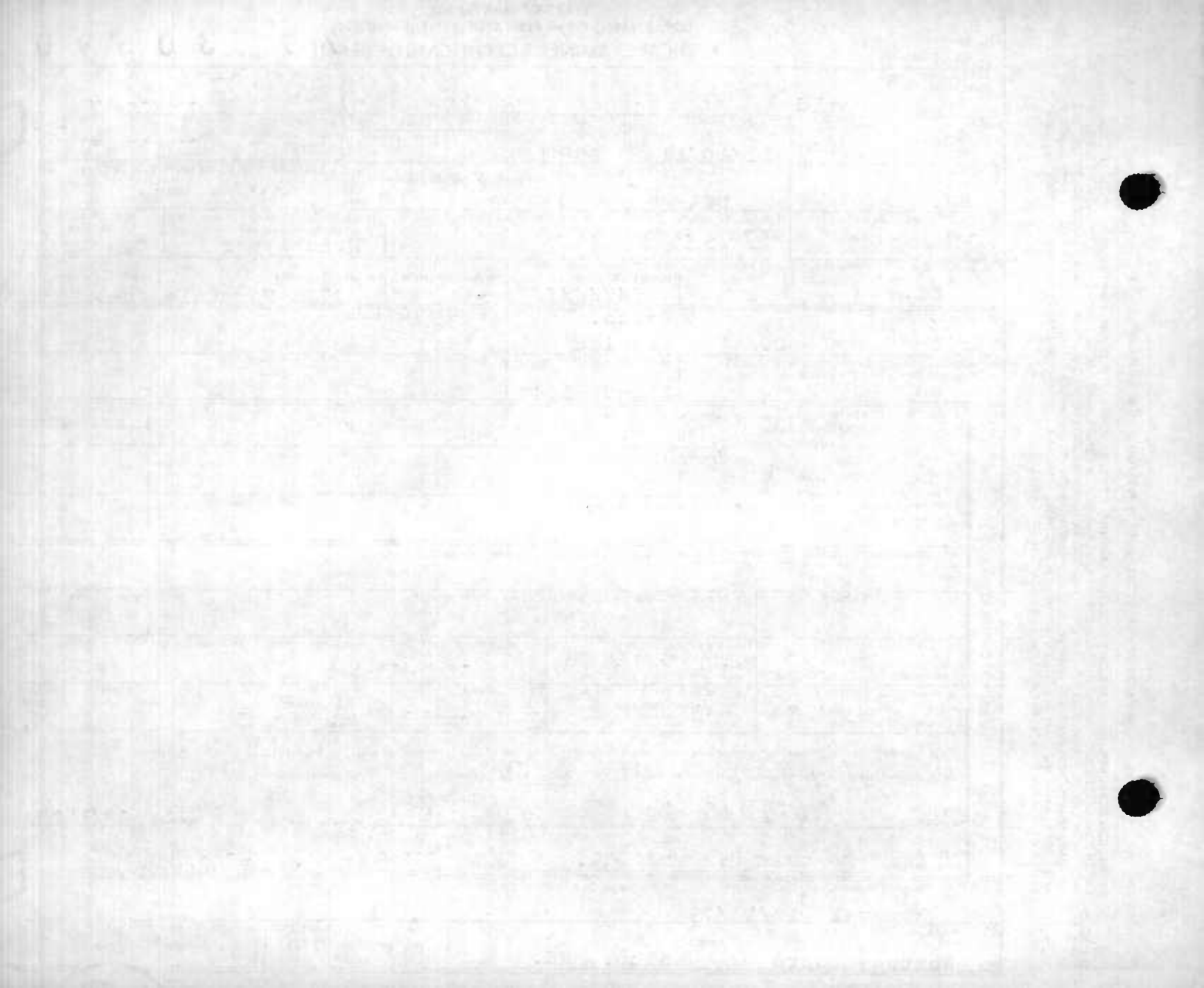
TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. GIVE PAGE 4 TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR THE FUNERAL DIRECTOR. PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITH-  
 AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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STATE OF MARYLAND  
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 30590

|  |  |                         |  |  |  |   |  |   |  |   |  |   |  |                       |  |  |  |  |  |
|--|--|-------------------------|--|--|--|---|--|---|--|---|--|---|--|-----------------------|--|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Ewald G. Schmidt</b>  |  |                         |  |  |  |   |  |   |  | 2a. DATE KNOWN OF DEATH<br>ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR <b>12 13 1979</b> |  | 2b. HOUR <b>M</b>   |  |                       |  |  |  |  |  |
| 3. SEX<br><b>Male</b>  |  | 4. RACE<br><b>White</b> |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR <b>11/10/11</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>68 YRS.</b> |  | IF UNDER 1 YR. MONTHS DAYS<br><b>68 YRS.</b>  |  | IF UNDER 24 HRS. HOURS MIN.<br><b>68 YRS.</b>   |  | 2c. DATE PRONOUNCED DEAD<br><b>12 13 1979</b>                                       |  | 2d. HOUR <b>1:50P</b> |  |  |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Md.</b>  |  |                         |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  |   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |   |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City, MD.</b>                  |  |                       |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore City</b>   |  |                         |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>University Hospital</b> |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Bricklayer</b>  |  |   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Construct.</b>                              |  |                       |  |  |  |  |  |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE <b>Md.</b>  |  |                         |  | 13b. COUNTY <b>Baltimore</b>   |  |   |  | 13c. CITY OR TOWN<br><b>Ferndale</b>  |  |   |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>   |  |                       |  | 13e. STREET ADDRESS<br><b>3725 Ferndale Ave.</b> |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Emil C. Schmidt</b>   |  |                         |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Ida Weber</b>  |  |   |  |   |  |   |  |   |  |                       |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br><b>No</b>   |  |                         |  | 16b. SOCIAL SECURITY NO.<br><b>215-09-1644</b>   |  |   |  | 17. INFORMANT ADDRESS   |  |   |  |   |  |                       |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Gunshot wound of head</b><br>955-4<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost:<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                   |  |                         |  |  |  |   |  |   |  |   |  |   |  |                       |  |  |  |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).  |  |                         |  |  |  |   |  |   |  |   |  |   |  |                       |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  |                         |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |  |   |  |   |  |   |  | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |                       |  |  |  |  |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |  |                         |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>11 xx 12 13 1979</b>   |  |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)<br><b>self inflicted</b>  |  |   |  |   |  |                       |  |  |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK   |  |                         |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)<br><b>home</b>   |  |   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br><b>3725 Ferndale Ave. Balto. Md.</b>   |  |   |  |   |  |                       |  |  |  |  |  |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |  |                         |  |  |  |   |  |   |  |   |  |   |  |                       |  |  |  |  |  |
| ACTUAL SIGNATURE<br><b>H. R. Guard</b>   |  |                         |  | TITLE (SPECIFY)<br><b>Assistant</b>  |  |   |  | DATE SIGNED<br><b>12/14/79</b>  |  |   |  |   |  |                       |  |  |  |  |  |
| EXAMINER'S NAME (TYPE OR PRINT)<br><b>Hormez R. Guard, M.D.</b>  |  |                         |  | ADDRESS<br><b>111 Penn St. Balto., MD.</b>   |  |   |  |   |  |   |  |   |  |                       |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Removal</b>  |  |                         |  | 23b. DATE<br><b>12/14/79</b>   |  |   |  | 23c. NAME OF CEMETERY OR CREMATORY  |  |   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE  |  |                       |  |  |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Anatomy Board</b>   |  |                         |  | ADDRESS<br><b>Balto., Md.</b>  |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>DEC 19 1979</b>   |  |   |  | 25b. REGISTRAR'S SIGNATURE<br><b>Robert M. Brady</b>                                |  |                       |  |  |  |  |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  |   | 7 9 3 0 5 9 1<br>REG. NO.  |   |  |  |
|---|--|--|--|---|--|---|--|--|
| 1. FOR STATE REGISTRAR  |  |  |  |   | 2a. DATE OF DEATH  |   |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) <i>CATHERINE JOHANNA SCHNEIDER</i>  |  |  |  |   | MONTH DAY YEAR <i>12/ 4/ 1979</i>  |   |  |  |
| 3 SEX <i>F</i>  |  |  |  |   | 2b. HOUR <i>12 PM</i>  |   |  |  |
| 4 RACE <i>W</i>   |  |  |  |   | 5. DATE OF BIRTH   |   |  |  |
| 6 AGE (IN YEARS LAST BIRTHDAY) <i>85</i> YRS  |  |  |  |   | 7. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS  |   |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>MD.</i>  |  |  |  |   | 7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>   |   |  |  |
| 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>   |  |  |  |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><i>BALTIMORE CITY</i> MD.                            |   |  |  |
| 10. CITY OR TOWN OF DEATH <i>BALTIMORE</i> ✓  |  |  |  |   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br><i>ST. AGNES HOSPITAL</i> ✓       |   |  |  |
| 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE) <i>HOUSEWIFE</i>   |  |  |  |   | 12b. KIND OF BUSINESS OR INDUSTRY  |   |  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE <i>MD.</i> 13b. COUNTY <i>BALTO.</i> 13c. CITY OR TOWN <i>CATONVILLE</i>   |  |  |  |   | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   |  |  |
| 14. FATHER'S NAME<br>FIRST <i>JOHN</i> MIDDLE <i>J.</i> LAST <i>MAHLE</i>   |  |  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST <i>MARY</i> MIDDLE <i>KELLER</i>                           |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i>   |  |  |  |   | 16b. SOCIAL SECURITY NO. <i>213-74-1365</i>  |   |  |  |
| 17. INFORMANT <i>MR. KARL SCHNEIDER</i>   |  |  |  |   | ADDRESS <i>1765 WEST FRIENDSHIP RD. SYKEVILLE MD.</i>  |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I: DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <i>End stage renal failure</i><br><i>586-</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) _____<br>(c) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |  |  |   |  |   |  |  |
| PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)  |  |  |  |   |  |   |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)    |  |   |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                 |  |   |  |  |
| 22a. I certify that (X) (this hospital) attended the deceased from <i>Dec 6</i> , 19 <i>79</i> , to <i>Dec 11</i> , 19 <i>79</i> , that (1) (he) last saw the deceased alive on <i>Dec 11</i> , 19 <i>79</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (do) (do not) view the body after death.   |  |  |  |   |  |   |  |  |
| 22b. SIGNATURE <i>Dr-HSLH Hung</i>  |  |  |  | DEGREE  |  | 22c. DATE SIGNED <i>12-11-79</i>  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Dr-HSLH Hung</i>   |  |  |  | 22e. ADDRESS <i>900 CATON AVE. BALTIMORE, MD. 21229</i>                           |  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE  |  |  |
| <i>BURIAL</i>   |  | <i>12-13-79</i>  |  | <i>LORRAINE PARK</i>  |  | <i>BALTO. MD.</i>   |  |  |
| 24. FUNERAL DIRECTOR<br>NAME <i>FRANK E.H. 6601 FRED. AVE.</i> ADDRESS  |  |  |  | 25a. DATE REC'D. BY REGISTRAR <i>DEC 17 1979</i>                                  |  |   |  |  |

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ST. JAMES' PARISH

BALTIMORE CITY

BALTIMORE ST. JAMES' PARISH

ST. JAMES' PARISH BALTIMORE, MD. 21202

*[Handwritten signature]*

ST. JAMES'

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

7 9 3 0 5 9 2

|  |  |   |  |   |              |  |                   |  |             |                               |              |   |  |
|--|--|---|--|---|--------------|--|-------------------|--|-------------|-------------------------------|--------------|---|--|
| 1. FOR<br>STATE<br>REGISTRAR   |  | 1. DECEASED NAME<br>(TYPE OR PRINT)   |  | FIRST<br>CARL   | MIDDLE<br>A. | LAST<br>SCHOPPER   | 2a. DATE OF DEATH |  | MONTH<br>12 | DAY<br>13                     | YEAR<br>1979 | 2b. HOUR<br>3:40 AM   |  |
| 3. SEX<br>MALE   |  | 4. RACE<br>Caucasian white  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>12-22-94  |              | 6. AGE (IN YEARS LAST BIRTHDAY)<br>84 YRS.   |                   | IF UNDER 1 YEAR<br>MONTHS DAYS   |             | IF UNDER 24 HRS<br>HOURS MIN. |              |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>New York  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |              | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Balto. City MD.  |                   |  |             |                               |              |   |  |
| 10. CITY OR TOWN OF DEATH<br>Balto. Md.  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Good Samaritan |  |   |              | 12a. USUAL OCCUPATION<br>(DIFF. OF WORK FOR MOST OF WORKING LIFE)<br>Ret. Personnel Officer  |                   | 12b. KIND OF BUSINESS OR INDUSTRY<br>Govt.   |             |                               |              |   |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  |   |  |   |              | 13a. STATE<br>Md.  |                   | 13b. COUNTY  |             | 13c. CITY OR TOWN<br>Balto.   |              | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>CARL A. Schopper   |  |   |  |   |              | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Sophie Louise Deutschle   |                   |  |             |                               |              |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)   |  | 17. INFORMANT<br>Wife:  |              | ADDRESS<br>1604 Hartsdale  |                   | Mrs. Grace Schopper Balto. Md. 21239   |             |                               |              |   |  |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) MULTIPLE MYELOMA<br>2030<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(b)<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) |  |   |  |   |              |  |                   |  |             |                               |              | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br>atherosclerotic Cardiovascular disease  |  |   |  |   |              |  |                   |  |             |                               |              |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |              | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |                   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |             |                               |              |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |              |  |                   |  |             |                               |              |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |              |  |                   |  |             |                               |              |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 12-9-1979 to 12-13-1979, that (I) (we) lost saw the deceased alive on 12-13-1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                              |  |   |  |   |              |  |                   |  |             |                               |              |   |  |
| 22b. SIGNATURE<br>Krishna P. Kumar   |  |   |  |   |              | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |                   | 22c. DATE SIGNED<br>12-13-79   |             |                               |              |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>KRISHNA P. KUMAR  |  |   |  |   |              | 22e. ADDRESS<br>Good Samaritan Hospital  |                   |  |             |                               |              |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial  |  | 23b. DATE<br>12/17/79   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Loudon Park Cemetery  |              | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Balto. Md.   |                   |  |             |                               |              |   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Leonard J. Ruck, Inc. 5305 Harford Rd. 21214   |  |   |  |   |              | 25a. DATE REC'D. BY REGISTRAR<br>DEC 14 1979   |                   | 25b. REGISTRAR'S SIGNATURE<br>[Signature]  |             |                               |              |   |  |

THE UNIVERSITY OF CHICAGO  
LIBRARY

*[Faint, mostly illegible handwritten text and markings across the page, possibly bleed-through from the reverse side.]*

DEC 1 1954  
*[Signature]*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  |   |  |  |  |  |  |
|---|--|--|--|---|--|--|--|--|--|
| 1. FOR STATE REGISTRAR  |  | 7 9 3 0 5 9 3<br>REG. NO.  |  |   |  |  |  |  |  |
| 1. DECEASED NAME (TYPE OR PRINT)  |  | FIRST MIDDLE LAST<br>WILLIAM MCKINLEY SCHRAMM  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br>12/20/79  |  | 2b. HOUR<br>10:16 P M  |  |  |  |
| 3. SEX<br>Male  |  | 4. RACE<br>White   |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>Aug. 13, 1896  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>83 YRS.   |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN      |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.   |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>St. Agnes Hospital |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Florist (RET)  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Self-Employ.  |  |  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |  |  |   |  |  |  |  |  |
| 13a. STATE<br>Maryland  |  | 13b. COUNTY<br>AnneArundel   |  | 13c. CITY OR TOWN<br>Pasadena   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                            |  | 13e. STREET ADDRESS<br>Rt. 9 Box 1, Mountain Rd. |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>Louis Schramm, Sr.   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Fredericka Conrad  |  |   |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>NO   |  | 16b. SOCIAL SECURITY NO<br>N/A   |  | 17. INFORMANT ADDRESS Same as # 13<br>219-26-1353 Miss Evelyn J. Schramm (Daughter)   |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cardio-respiratory arrest</u><br>5609<br>DUE TO, OR AS A CONSEQUENCE OF (b) <u>Probable hypovolemia, cardiac failure</u><br>DUE TO, OR AS A CONSEQUENCE OF (c) <u>Chronic renal failure; KUD Chronic CHF</u><br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <u>Ca 9 prostate tumor, Chronic renal failure</u><br><u>Post renal polyuria</u> |  |  |  |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH     |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |  |  |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>12/19/79</u> to <u>12/20/79</u> , that (I) (we) last saw the deceased alive on <u>12/19/79</u> at <u>10:15 PM</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.  |  |  |  |   |  |  |  |  |  |
| 22b. SIGNATURE<br><u>Antoinette Navarro</u>   |  | DEGREE   |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>                  |  | 22c. DATE SIGNED<br><u>12/20/79</u>  |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Dr. ANTOINETTE NAVARRO   |  | 22e. ADDRESS   |  |   |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial   |  | 23b. DATE<br>27 DEC '79  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Loudon Park Cem.  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br>Baltimore Md.   |  |  |  |
| 24. FUNERAL DIRECTOR NAME<br>SINGLETON FUNERAL HOME, GLENBURNIE, MD.  |  | ADDRESS  |  | 25a. DATE REC'D. BY REGISTRAR<br>DEC 28 1979  |  | 25b. REGISTRAR'S SIGNATURE<br><u>Anthony M. M...</u>   |  |  |  |



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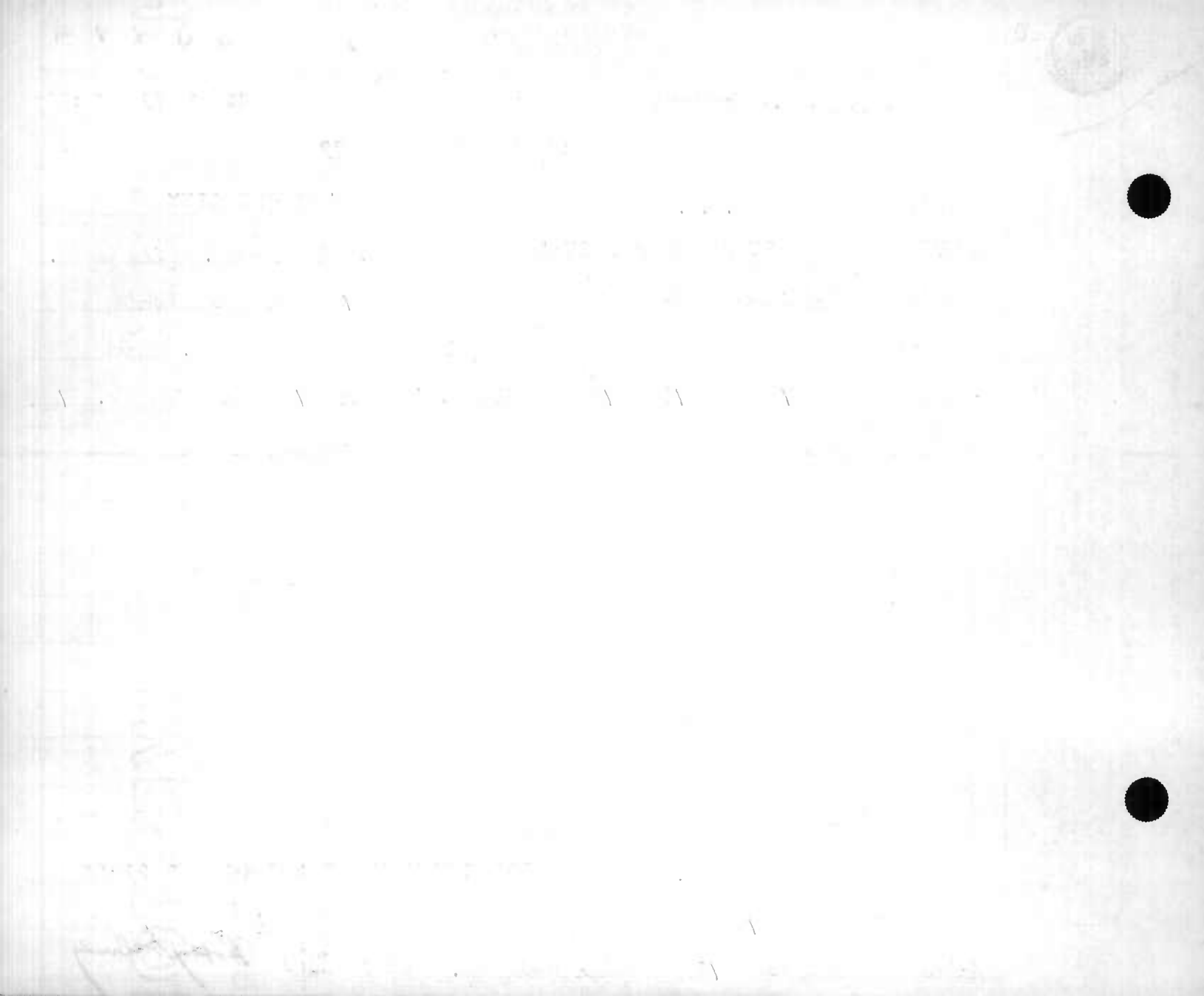


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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  |   |  |   |  |                     |  | 79 30594                 |  |
|---|--|---|--|---|--|---|--|---------------------|--|--------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |  | FIRST   |  | MIDDLE  |  | LAST  |  | 2a. DATE OF DEATH   |  | MONTH DAY YEAR           |  |
| Charles H., Schuhart  |  |   |  |   |  |   |  | 12/ 1/ 79           |  | 10:31 PM                 |  |
| 3. SEX  |  | 4. RACE   |  | 5. DATE OF BIRTH  |  | 6. AGE (IN YEARS LAST BIRTHDAY)                                     |  | 7. IF UNDER 1 YEAR  |  | 8. IF UNDER 24 HRS       |  |
| M   |  | W   |  | 08/ 25/ 00  |  | 79  |  | MONTHS DAYS         |  | HOURS MIN.               |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  | 7b. CITIZEN OF WHAT COUNTRY?  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |  |                     |  |                          |  |
| Maryland  |  | U.S.A.  |  |   |  | BALTIMORE CITY  |  |                     |  | MD.                      |  |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)  |  | 12b. KIND OF BUSINESS OR INDUSTRY                                   |  |                     |  |                          |  |
| BALTIMORE   |  | ST AGNES HOSPITAL   |  | Policeman-ret.  |  | City Gov't.   |  |                     |  |                          |  |
| 13a. STATE  |  | 13b. COUNTY   |  | 13c. CITY OR TOWN   |  | 13d. INSIDE CITY LIMITS?  |  | 13e. STREET ADDRESS |  |                          |  |
| Maryland  |  | Baltimore   |  | Arbutus   |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 1259 Greystone Road |  |                          |  |
| 14. FATHER'S NAME   |  | 15. MOTHER'S MAIDEN NAME  |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)  |  | 16b. SOCIAL SECURITY NO.  |  | 17. INFORMANT       |  | ADDRESS                  |  |
| George  |  | Elizabeth   |  | yes   |  | 213-32-1560   |  | Edith L. Schuhart   |  | 1259 Greystone Rd. 21227 |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) 4413<br>DUE TO, OR AS A CONSEQUENCE OF (b) Ruptured abdominal aorta<br>DUE TO, OR AS A CONSEQUENCE OF (c)   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |   |  |   |  |                     |  |                          |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)   |  | A acute inferior myocardial infarct   |  |   |  |   |  |                     |  |                          |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?      |  |                     |  |                          |  |
|   |  |   |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | YES <input type="checkbox"/> NO <input type="checkbox"/>            |  |                     |  |                          |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |                     |  |                          |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |                     |  |                          |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost<br>saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death. |  |   |  |   |  |   |  |                     |  |                          |  |
| 22b. SIGNATURE  |  | DEGREE  |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>                  |  | 22c. DATE SIGNED  |  |                     |  |                          |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  | 22e. ADDRESS  |  |   |  | 12/1/79   |  |                     |  |                          |  |
| KYAW N KUNT   |  | 900 CATON AVE BALTIMORE MD 21229  |  |   |  |   |  |                     |  |                          |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)  |  | 23b. DATE   |  | 23c. NAME OF CEMETERY OR CREMATORY  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE                          |  |                     |  |                          |  |
| burial  |  | 12/5/79   |  | Loudon Park Cemetery  |  | Baltimore City Maryland   |  |                     |  |                          |  |
| 24. FUNERAL DIRECTOR<br>NAME  |  | ADDRESS   |  | 25a. DATE REC'D. BY REGISTRAR   |  | 25b. REGISTRAR'S SIGNATURE  |  |                     |  |                          |  |
| Ambrose Funeral Home  |  | 1328 Sulphur Spring Rd.   |  | DEC 3 1979  |  | [Signature]   |  |                     |  |                          |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death and may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR  
1 - STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

7 9 3 0 5 9 5

REG. NO.

|   |   |   |   |   |
|---|---|---|---|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>ALEXANDER SCHULTZ</b>   |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>DEC. 25 1979</b>  |   | 2b. HOUR<br>M<br><b></b>  |
| 3. SEX<br><b>MALE</b>   | 4. RACE<br><b>WHITE</b>   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>FEB 15 1906</b>  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>73</b> YRS.   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MARYLAND</b>  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.                               |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>323 S. DUNCAN ST.</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>RETIRED STEEL WORKER</b> | 12b. KIND OF BUSINESS OR INDUSTRY<br><b></b>  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>MARYLAND</b> |   | 13b. COUNTY<br><b>BALTIMORE</b>   | 13c. CITY OR TOWN<br><b>BALTIMORE</b>   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>UNKNOWN</b>  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>UNKNOWN</b>   |   |   |

|   |  |  |
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| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b> | 16b. SOCIAL SECURITY NO<br>(IF YES, GIVE WAR OR DATES)<br><b>213 01 0825</b> | 17. INFORMANT<br>ADDRESS<br><b>MRS. J. SCHULTZ 323 S. DUNCAN ST.</b> |
|---|--|--|

|   |  |   |
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| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiac Arrhythmia</b><br>410 -<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Postoperative Hemorrhage</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b></b> |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br><b>10 days</b> |
|---|--|---|

|  |  |
|--|--|
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)<br><b>Pulmonary Embolism (1971) Acute MI (1971)</b> |  |
|--|--|

|   |   |  |  |
|---|---|--|--|
| 19a. DATE OF OPERATION<br><b>11-29-79</b> | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b></b> | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
|---|---|--|--|

|  |   |   |
|--|---|---|
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b> | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)<br><b></b> |
|--|---|---|

|   |   |  |
|---|---|--|
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)<br><b></b> | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br><b></b> |
|---|---|--|

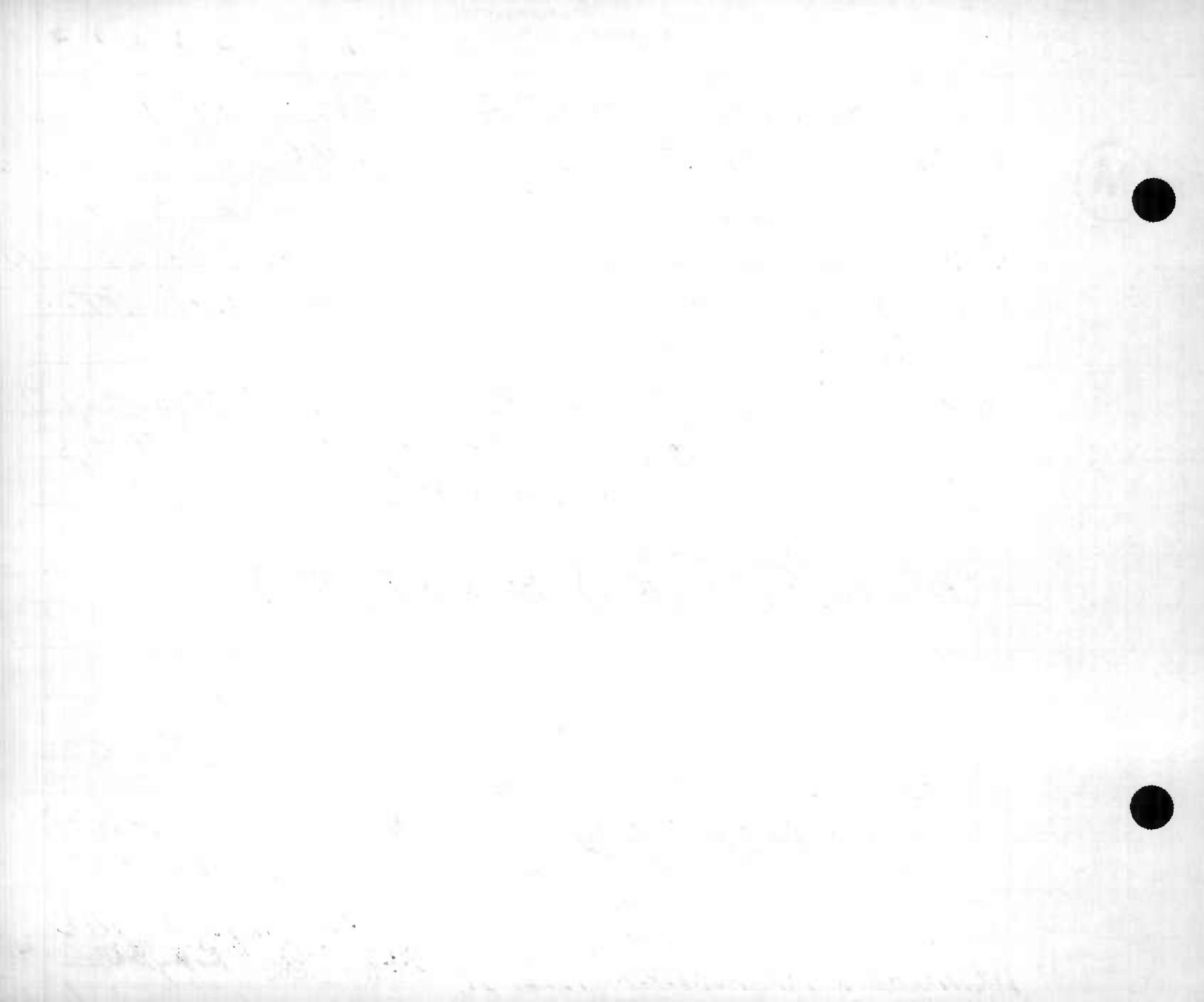
22. I certify that (I) (this hospital) attended the deceased from **1971**, 19 **11-29-79**, to **11-29-79**, that (I) (we) last saw the deceased alive on **11-29-79**, 19 **11-29-79**, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

|  |                   |                                     |
|--|-------------------|-------------------------------------|
| 22b. SIGNATURE<br><b>Theo. V. Niznik</b> | DEGREE<br><b></b> | 22c. DATE SIGNED<br><b>12-28-79</b> |
|--|-------------------|-------------------------------------|

|  |  |
|--|--|
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Theo. V. NIZNIK MD</b> | 22e. ADDRESS<br><b>429 S. Chester St 21231</b> |
|--|--|

|  |                              |   |   |
|--|------------------------------|---|---|
| 23a. BURIAL, CREMATION, REMOVAL<br>(TYPE)<br><b>BURIAL</b> | 23b. DATE<br><b>12/27/79</b> | 23c. NAME OF CEMETERY OR CREMATORY<br><b>SACRED HEART</b> | 23d. LOCATION<br>(CITY OR TOWN) COUNTY STATE<br><b>BALTIMORE MD</b> |
|--|------------------------------|---|---|

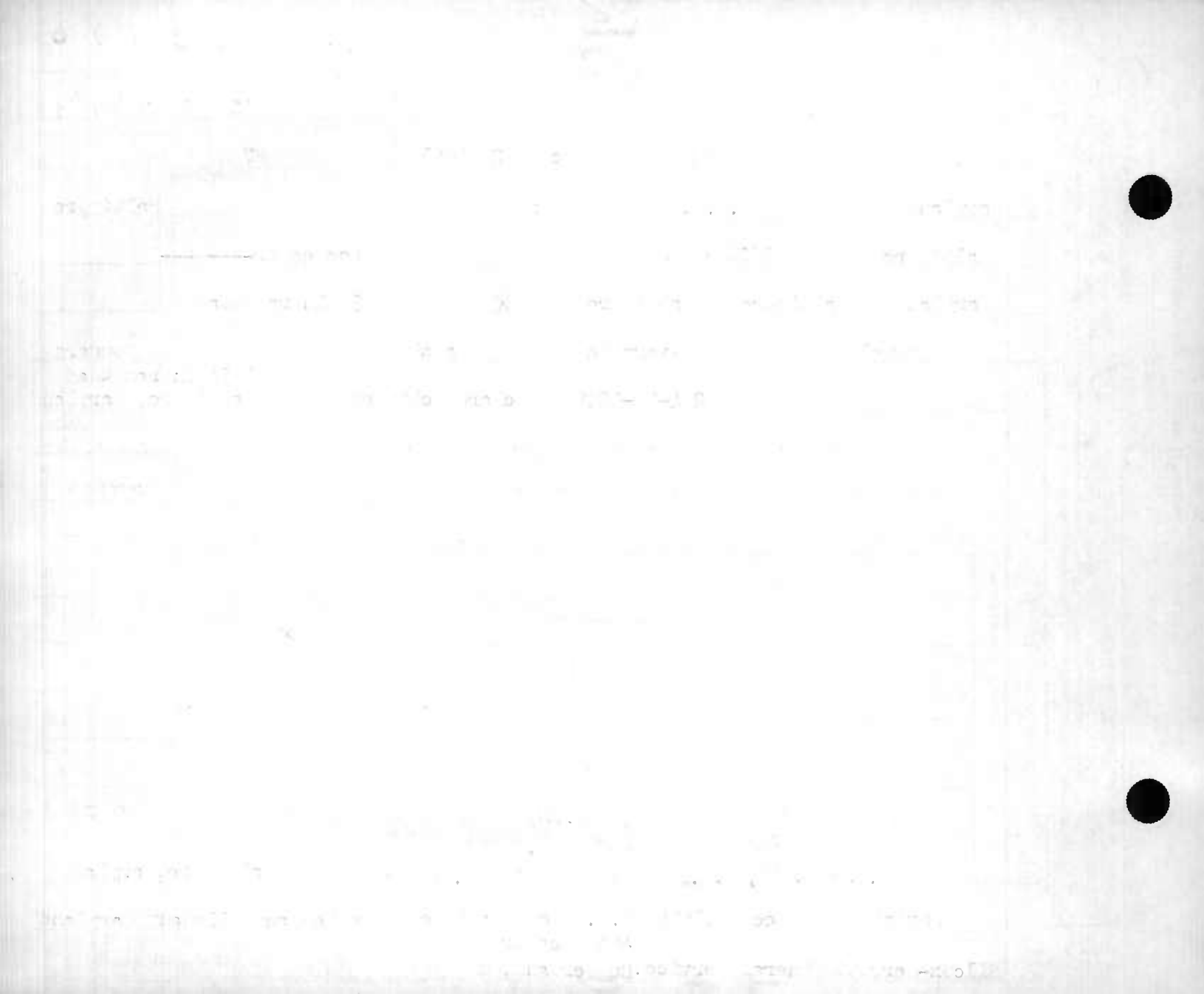
|   |                                 |  |  |
|---|---------------------------------|--|--|
| 24. FUNERAL DIRECTOR<br>NAME<br><b>RAYMOND L. KACZOROWSKI</b> | ADDRESS<br><b>3525 Fleet St</b> | 25a. DATE REC'D. BY REGISTRAR<br><b>JAN 2 1980</b> | 25b. REGISTRAR'S SIGNATURE<br><b>Anthony Maloney</b> |
|---|---------------------------------|--|--|



TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of one.

| FOR<br>STATE<br>REGISTRAR  |  | STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |   | 7 9 3 0 5 9 6<br>REG. NO.  |  |
|--|--|---|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>PEARL SCHUPFER</b>   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>12 06 79</b>  |   | 2b. HOUR<br><b>9<sup>30</sup> A.M.</b>   |  |
| 3. SEX<br><b>FEMALE</b>  | 4. RACE<br><b>WHITE</b>  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Dec 12 1891</b>  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>87 YRS.</b>  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>   | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore MD.</b>   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>1636 INGRAM ROAD</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Housekeeper</b>          |  | 12b. KIND OF BUSINESS OR INDUSTRY  |
| 13a. STATE<br><b>Maryland</b>  | 13b. COUNTY<br><b>Baltimore</b>  | 13c. CITY OR TOWN<br><b>Baltimore</b>   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>1636 Ingram Road</b>   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Emmanuel Eversole</b>   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Sarah Souders</b>   |   | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <input type="checkbox"/> (IF YES, GIVE WAR OR DATES)<br><b>No</b> |  |
| 16b. SOCIAL SECURITY NO<br><b>214-74-7289</b>  |  | 17. INFORMANT<br><b>Richard Schupfer</b>  |   | ADDRESS<br><b>1636 Ingram Road<br/>Baltimore, Maryland</b>   |  |
| 11. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>vascular collapse</b><br>DUE TO, OR AS A CONSEQUENCE OF:<br>(b) <b>hepatic failure</b><br>DUE TO, OR AS A CONSEQUENCE OF:<br>(c) <b>carcinoma, primary not found (? pane?)</b>  |  |   |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>min</b><br><b>weeks</b><br><b>years</b> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a):   |  |   |   |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, GIVE MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>1 Nov</b> , 19 <b>79</b> , to <b>6 Dec</b> , 19 <b>79</b> , that (I) (we) lost<br>saw the deceased alive on <b>15 Nov</b> , 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death. |  |   |   |  |  |
| 22b. SIGNATURE<br><b>Dan H. McDougal MD</b>  |  | DEGREE<br><b>MD.</b>  |   | 22c. DATE SIGNED<br><b>6 Dec 79</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>DAN H. McDOUGAL, M.D.</b>  |  | 22e. ADDRESS<br><b>300 E. JOPPA ROAD Baltimore, Maryland</b>  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>Dec 10, 1979</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>S.S. Peter &amp; Paul Cem</b>   |  |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Cumberland Allegany Maryland</b>  |  | 23e. DATE REC'D. BY REGISTRAR<br><b>DEC 11 1979</b>   |   |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Silcox-Merritt Funeral Service, Cumberland, Md</b>  |  | ADDRESS<br><b>404 Decatur St</b>  |   | 25b. REGISTRAR'S SIGNATURE<br><b>Robert McCreedy</b>   |  |





DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  |   |  |   |   |   |  | 7 9 3 0 5 9 7 |  |
|---|--|---|--|---|--|---|---|---|--|---------------|--|
| 1. FOR<br>STATE<br>REGISTRAR  |  |   |  |   | REG. NO.   |   |   |   |  |               |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>LENA SCHWARTZ  |  |   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>DEC 13 1979   |   |   | 2b. HOUR<br>10 <sup>30</sup> A  |  |               |  |
| 3. SEX<br>FEMALE  |  | 4. RACE<br>CAUC.  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>9 28 89   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>90 YRS   |   | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN  |  |               |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN)<br>RUSSIA   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD                                       |   |   |  |               |  |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>SINAI HOSPITAL |  |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>MERCHANT   |   | 12b. KIND OF BUSINESS OR INDUSTRY<br>RETAIL         |   |  |               |  |
| 13a. STATE<br>MARYLAND  |  | 13b. COUNTY<br>BALTO.   |  | 13c. CITY OR TOWN<br>RANDALLSTOWN   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   | 13e. STREET ADDRESS<br>APT. 204<br>9701 BRANCHLEIGH RD. #21133  |  |               |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>UNKNOWN   |  |   |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>UNKNOWN   |   |   |   |  |               |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>NO  |  |   | 16b. SOCIAL SECURITY NO  |   | 17. INFORMANT<br>MR. MELVIN SCHWARTZ<br>9701 BRANCHLEIGH RD., APT. 204 #21133  |   |   |   |  |               |  |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cardiopulmonary arrest</u><br>4140 } DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which <u>arteriosclerotic heart disease</u><br>gave rise to immediate (b) <u>coronary insufficiency</u><br>cause (a), stating the (c) <u>coronary insufficiency</u><br>underlying cause last<br>DUE TO, OR AS A CONSEQUENCE OF<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):<br><u>None</u> |  |   |  |   |  |   |   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br>1 day<br>3 years   |  |               |  |
| 19a. DATE OF OPERATION  |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |   | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |               |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |   |   |   |  |               |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |   |   |   |  |               |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>Dec 1</u> , 19 <u>76</u> , to <u>Dec 13</u> , 19 <u>79</u> , that (I) <u>lost</u><br>saw the deceased alive on <u>Dec 13</u> , 19 <u>79</u> , and that in (my) <u>own</u> opinion death occurred on the date and hour and from the causes stated<br>above, (I) <u>did</u> (did not) view the body after death.  |  |   |  |   |  |   |   |   |  |               |  |
| 22b. SIGNATURE<br><u>Manuel Levin MD</u> DEGREE   |  |   |  |   | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |   |   | 22c. DATE SIGNED<br>12/13/79  |  |               |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>MANUEL LEVIN MD  |  |   |  |   | 22e. ADDRESS<br>6101 PK HOP AVE BALTO MD 21215   |   |   |   |  |               |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>BURIAL  |  |   | 23b. DATE<br>DEC. 16, 1979   |   | 23c. NAME OF CEMETERY OR CREMATORY<br>WORKMEN CIRCLE   |   | 23d. LOCATION<br>BALTIMORE COUNTY MARYLAND          |   |  |               |  |
| 24. FUNERAL DIRECTOR<br>NAME SOL LEVINSON & BROS., INC.<br>ADDRESS 6010 REISTERSTOWN RD. BALTO., MD 21215   |  |   |  |   | 25a. DATE REC'D. BY REGISTRAR<br>DEC 20 1979   |   | 25b. REGISTRAR'S SIGNATURE<br><u>Henry McCreedy</u> |   |  |               |  |





DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

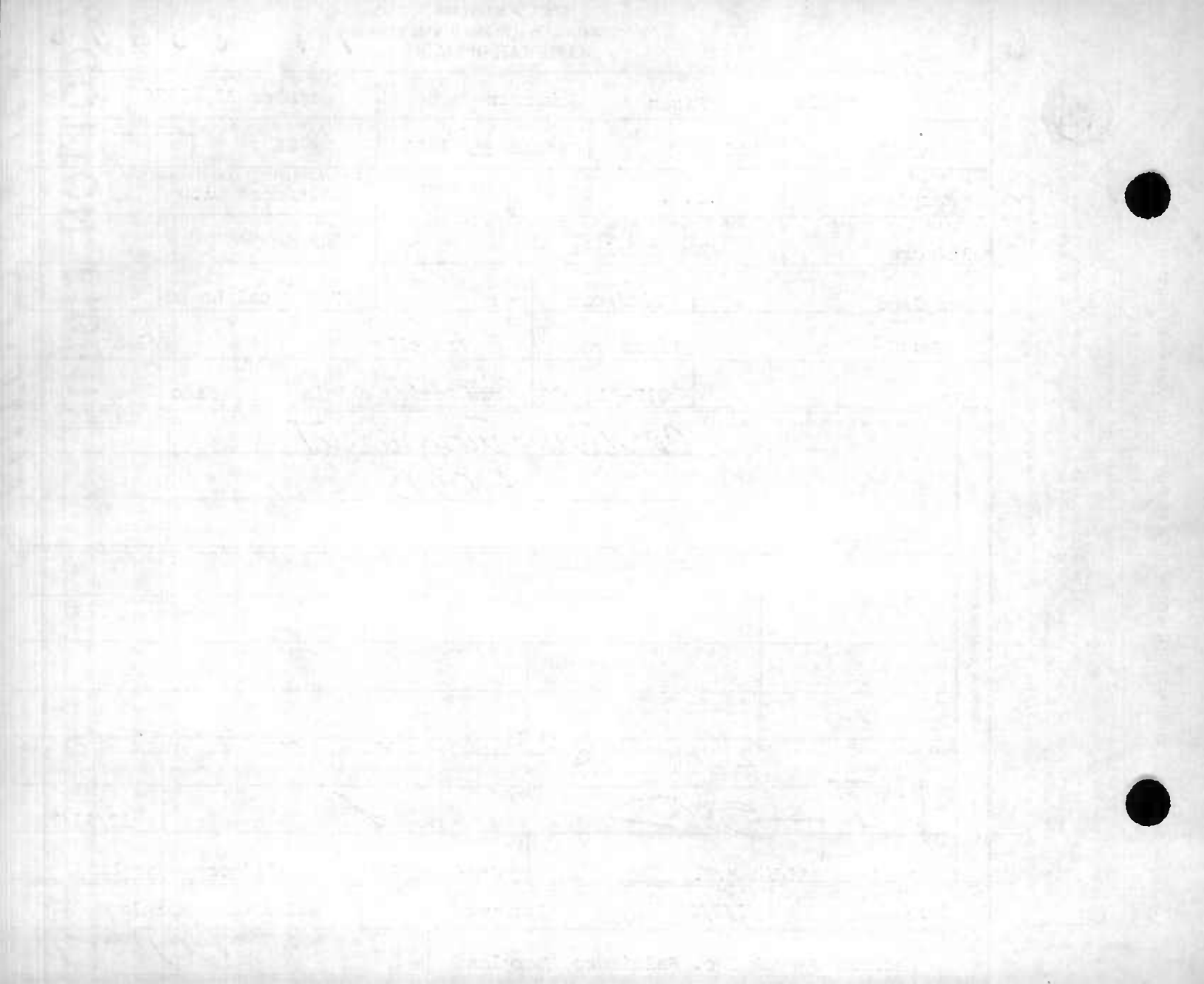
7 9 3 0 5 9 8

1- FOR  
STATE  
REGISTRAR

|  |  |  |   |  |  |  |   |  |  |
|--|--|--|---|--|--|--|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Viola Dixon Schwartz</b>   |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>December 31, 1979</b>         |  | 2b. HOUR<br>M  |  |   |  |  |
| 3 SEX<br><b>Female</b>   |  | 4 RACE<br><b>White</b>   |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>January 19, 1880</b>  |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br>YRS. MONTHS DAYS<br><b>99</b>  |   |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |   | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b>   |   |  |  |
| 10 CITY OR TOWN OF DEATH<br><b>Baltimore</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>4706 Catalpha Rd</b> |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Housewife</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |  |
| 13a. STATE<br><b>Maryland</b>  |  |  | 13b. COUNTY<br><b>Baltimore</b>   |  | 13c. CITY OR TOWN<br><b>Baltimore</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Samuel Dixon</b>  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Arabella Palmer</b> |  |  |  |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>217-01-0923</b>  |   | 17 INFORMANT<br>ADDRESS<br><b>Miss Doris Schlein Same</b>  |  |  |   |  |  |
| 18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiovascular arrest</b><br><b>4292</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(b) <b>ASCVD</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) |  |  |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |  |   |  |  |  |   |  |  |
| 19a. DATE OF OPERATION   |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                        |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19              |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |   |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>6/23</b> , 19 <b>76</b> , to <b>4-9</b> , 19 <b>79</b> , that (I) (we) last saw the deceased alive on <b>4-9</b> , 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.         |  |  |   |  |  |  |   |  |  |
| 22b. SIGNATURE<br><b>Veniedo Alidio M.D.</b>   |  |  |   |  |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |   | 22c. DATE SIGNED<br><b>12/31/79</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Veniedo Alidio M.D.</b>  |  |  |   |  |  | 22e. ADDRESS<br><b>4808 Harford Rd Baltimore, Maryland</b>   |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |  |  | 23b. DATE<br><b>1/2/80</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Parkwood</b>                                |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore, Maryland</b>                        |  |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Leonard J Ruck Inc. Baltimore, Maryland</b>   |  |  |   |  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JAN 5 1980</b>   |   |  |  |

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

|   |  |  |  |  |  |   |  |
|---|--|--|--|--|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>LILLIAN J. SCHWINN</b>   |  |  | 2a. DATE OF DEATH MONTH <b>12</b> DAY <b>18</b> YEAR <b>79</b> |  |  | 2b. HOUR <b>5 35</b> P.M.   |  |
| 3. SEX <b>F</b>   |  | 4. RACE <b>W</b>   |  | 5. DATE OF BIRTH MONTH <b>6</b> DAY <b>20</b> YEAR <b>25</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY) <b>54</b> YRS.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>M. C.</b>  |  | 7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY</b> MD.  |  |
| 10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>MERCY HOSPITAL</b> |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>RESTAURANT</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |
| 13a. STATE <b>MD.</b> 13b. COUNTY <b>BALTO</b> 13c. CITY OR TOWN <b>ESSEX</b>   |  |  |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 13e. STREET ADDRESS <b>13 L VALLEY ARBOR CT</b>   |  |
| 14. FATHER'S NAME FIRST <b>FRED</b> MIDDLE <b>BODFORD</b> LAST <b></b>  |  |  |  | 15. MOTHER'S MAIDEN NAME FIRST <b>UNK</b> MIDDLE <b></b> LAST <b></b>  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>   |  | 16b. SOCIAL SECURITY NO. <b>245 24 3988</b>  |  | 17. INFORMANT ADDRESS <b>BARY SCHWINN 1400K STRAWFLOWER RD</b>   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Hypoxemia</b><br>1629 } DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>metastatic Carcinoma of The Lung</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last }<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b></b><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>HOURS (24)</b><br><b>Before Oct 1979</b> |  |  |  |  |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)  |  |  |  |  |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |   |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>12/15</b> , 19 <b>79</b> , to <b>12/18</b> , 19 <b>79</b> , that (I) (we) lost saw the deceased alive on <b>12/18</b> , 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |  |  |  |  |   |  |
| 22b. SIGNATURE <b>John F. Salke</b> MD  |  |  |  | DEGREE <b>MD</b>   |  | 22c. DATE SIGNED <b>12/18/79</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>John F. Salke MD</b>   |  |  |  | 22e. ADDRESS <b>Mercy Hospital BALT. MD.</b>   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>   |  | 23b. DATE <b>12/21/79</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY <b>OAKLAWN</b>  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE <b>BALTO. MD.</b>   |  |
| 24. FUNERAL DIRECTOR NAME <b>J. G. CONNELLY</b> ADDRESS <b>300 MACE</b>   |  |  |  | 25a. DATE REC'D BY REGISTRAR <b>DEC 27 1979</b>  |  | 25b. REGISTRAR'S SIGNATURE <b>Anthony M. Brady</b>  |  |

BP

1. The first part of the paper is devoted to a discussion of the general properties of the system. It is shown that the system is stable and that the solution is unique. The second part of the paper is devoted to a discussion of the numerical solution of the system. It is shown that the numerical solution is stable and that the error is of order  $O(\Delta t)$ . The third part of the paper is devoted to a discussion of the physical interpretation of the results. It is shown that the results are in good agreement with the experimental data.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified by the funeral director.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  |   |  |   |  |  |  |   |  |          |  |
|---|--|---|--|---|--|---|--|--|--|---|--|----------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |  | FIRST   |  | MIDDLE  |  | LAST  |  | 2a. DATE OF DEATH  |  | MONTH DAY YEAR                                  |  | 2b. HOUR |  |
| MARGARET E. SCOTT   |  |   |  |   |  |   |  | 12/26/79   |  |   |  | 24 M     |  |
| 3. SEX  |  | 4. RACE   |  | 5. DATE OF BIRTH  |  | 6. AGE (IN YEARS LAST BIRTHDAY)                                     |  | IF UNDER 1 YEAR  |  | IF UNDER 24 HRS                                 |  |          |  |
| FEMALE  |  | WHITE   |  | 10 10 20  |  | 59  |  | MONTHS DAYS  |  | HOURS MIN                                       |  |          |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  | 7b. CITIZEN OF WHAT COUNTRY?  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |  |  |  |   |  |          |  |
| NORTH CAROLINA  |  | U.S.A.  |  |   |  | BALTIMORE CITY  |  |  |  |   |  |          |  |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)  |  | 12b. KIND OF BUSINESS OR INDUSTRY                                   |  |  |  |   |  |          |  |
| BALTIMORE   |  | ST. AGNES HOSPITAL  |  | SALESLADY   |  | SIBEL'S   |  |  |  |   |  |          |  |
| 13a. STATE  |  | 13b. COUNTY   |  | 13c. CITY OR TOWN   |  | 13d. INSIDE CITY LIMITS?  |  | 13e. STREET ADDRESS  |  |   |  |          |  |
| MARYLAND  |  | ---   |  | BALTIMORE   |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 1800 WILMINGTON AVE.   |  | 21230   |  |          |  |
| 14. FATHER'S NAME   |  | 15. MOTHER'S MAIDEN NAME  |  |   |  |   |  |  |  |   |  |          |  |
| WILLIAM   |  | LOU   |  | ALICE   |  | MAHAN   |  |  |  |   |  |          |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)   |  | 17. INFORMANT   |  | ADDRESS   |  |  |  |   |  |          |  |
| NO  |  | 118-09-6757   |  | ANN L. COSTA  |  | 3352 Bessent Rd.  |  | Jacksonville, Florida  |  | 32218   |  |          |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY.  |  |   |  |   |  |   |  |  |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |  |          |  |
| IMMEDIATE CAUSE (a) <i>Respiratory Failure</i>  |  |   |  |   |  |   |  |  |  |   |  |          |  |
| DUE TO, OR AS A CONSEQUENCE OF (b) <i>Chronic Pulmonary</i>   |  |   |  |   |  |   |  |  |  |   |  |          |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.  |  |   |  |   |  |   |  |  |  |   |  |          |  |
| DUE TO, OR AS A CONSEQUENCE OF (c) <i>Chronic Obstructive Pulmonary Disease</i>   |  |   |  |   |  |   |  |  |  |   |  |          |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |   |  |   |  |   |  |  |  |   |  |          |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |  | 20a. AUTOPSY?   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |  |   |  |          |  |
|   |  |   |  |   |  | YES <input type="checkbox"/> NO <input type="checkbox"/>            |  | YES <input type="checkbox"/> NO <input type="checkbox"/>       |  |   |  |          |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |  |  |   |  |          |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |  |  |   |  |          |  |
|   |  |   |  |   |  |   |  |  |  |   |  |          |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost<br>saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death. |  |   |  |   |  |   |  |  |  |   |  |          |  |
| 22b. SIGNATURE  |  | DEGREE  |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                  |  | 22c. DATE SIGNED  |  |  |  |   |  |          |  |
| Joseph H. Miller  |  | MD  |  |   |  | 12/26/79  |  |  |  |   |  |          |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  | 22e. ADDRESS  |  |   |  |   |  |  |  |   |  |          |  |
| Joseph H. MILLER  |  | 900 CATON AVE. BALTIMORE, MD. 21220   |  |   |  |   |  |  |  |   |  |          |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)  |  | 23b. DATE   |  | 23c. NAME OF CEMETERY OR CREMATORY  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE                          |  |  |  |   |  |          |  |
| BURIAL  |  | 12/31/79  |  | MEADOWRIDGE M EM. PK  |  | ELKRIDGE HOWARD   |  | MD.  |  |   |  |          |  |
| 24. FUNERAL DIRECTOR<br>NAME  |  | ADDRESS   |  | 25a. DATE REC'D. BY REGISTRAR   |  | 25b. REGISTRAR'S SIGNATURE  |  |  |  |   |  |          |  |
| HUBBARD FUNERAL HOME  |  | 4107 WILKENS AVE. 21229   |  | DEC 28 1979   |  | [Signature]   |  |  |  |   |  |          |  |

19 30000

BALTIMORE CITY

ST. AGNES HOSPITAL

BALTIMORE

900 CATON AVE., BALTIMORE, MD. 21229

Joseph A. Miller

*Handwritten signature*

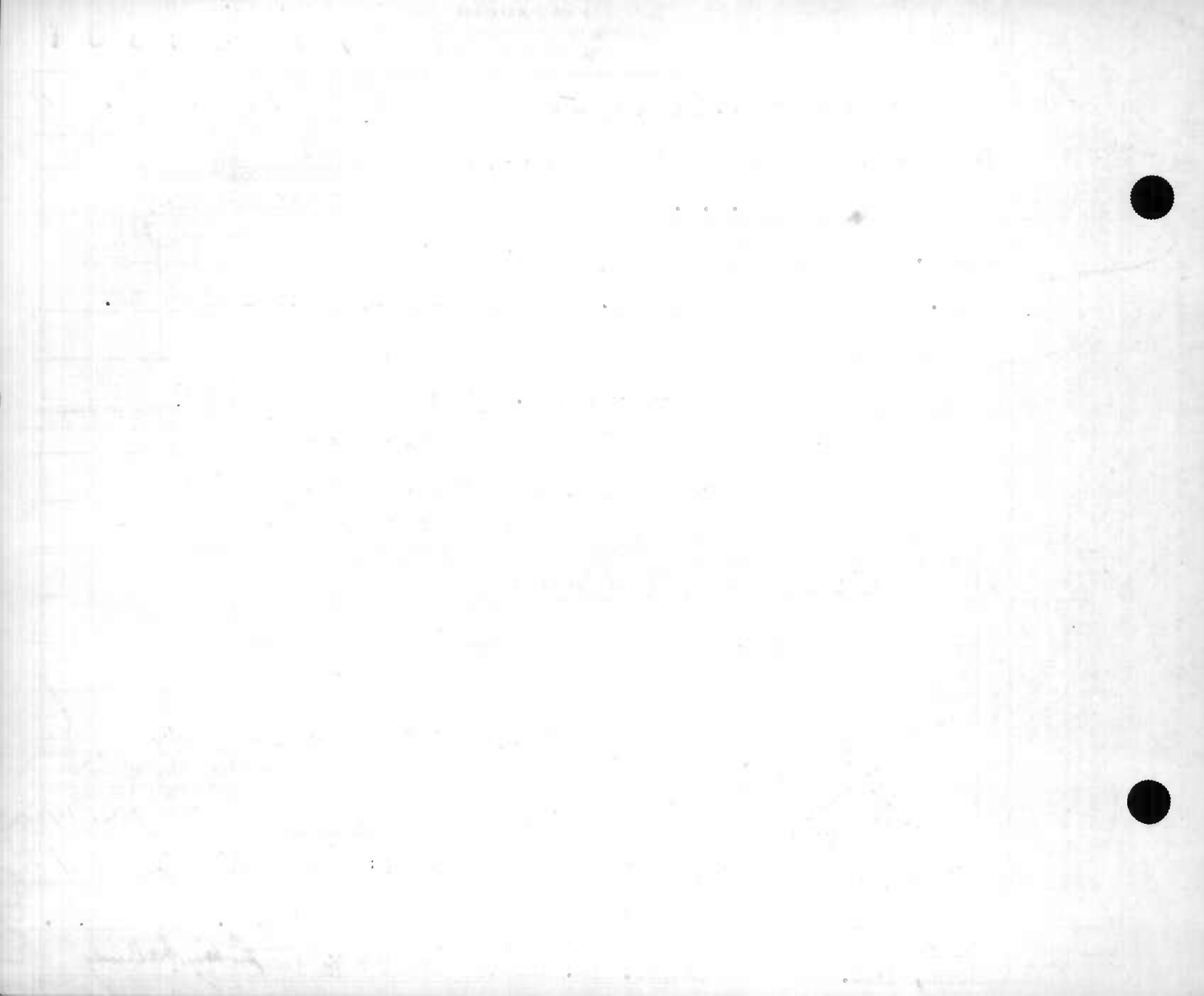
DEC 8 1979

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  |  |  |  |   |   |  | 7 9 3 0 6 0 1<br>REG. NO.  |  |   |  |                           |  |
|---|--|---|--|--|--|--|---|---|--|--|--|---|--|---------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Elizabeth J. Seibert</b>   |  |   |  |  |  |  |   |   |  | 2a. DATE OF DEATH<br>MONTH <b>12</b> DAY <b>24</b> YEAR <b>79</b>  |  |   |  | 2b. HOUR<br><b>6:30 A</b> |  |
| 3. SEX<br><b>Female</b>   |  | 4. RACE<br><b>Caucasian</b>   |  | 5. DATE OF BIRTH<br>MONTH <b>3</b> DAY <b>13</b> YEAR <b>13</b>  |  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>86</b> YRS.                 |   |  | IF UNDER 1 YEAR<br>MONTHS <b></b> DAYS <b></b>   |  | IF UNDER 74 HRS<br>HOURS <b></b> MIN. <b></b> |  |                           |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Virginia</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>    |  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD. |   |  |  |  |   |  |                           |  |
| 10. CITY OR TOWN OF DEATH<br><b>Balto.</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Edgewood Nursing Home</b> |  |  |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Housewife</b> |   |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Home</b> |  |  |   |  |                           |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE <b>Md.</b> 13b. COUNTY <b></b> 13c. CITY OR TOWN <b>Balto.</b>   |  |   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 13e. STREET ADDRESS<br><b>2912 Kings Ridge Rd.</b>                                   |   |   |  |  |  |   |  |                           |  |
| 14. FATHER'S NAME<br>FIRST <b>Unknown</b> MIDDLE <b></b> LAST <b></b>   |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>Unknown</b> MIDDLE <b></b> LAST <b></b>   |  |  |   |   |  |  |  |   |  |                           |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>no</b>  |  |   |  | 16b. SOCIAL SECURITY NO.<br><b>213-74-7767</b>   |  | 17. INFORMANT<br>ADDRESS <b>same</b>   |   |   |  | address <b></b>  |  |   |  |                           |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cerebral Arteriosclerosis -</b><br><b>4370</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) <b>DUE TO, OR AS A CONSEQUENCE OF A.S. C.V.D. (Hem). Fibrillation.</b><br>(c) <b>DUE TO, OR AS A CONSEQUENCE OF GENERAL Arteriosclerosis</b> |  |   |  |  |  |  |   |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>-</b>   |  |   |  |                           |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)<br><b>COAR D Diabetes-</b>  |  |   |  |  |  |  |   |   |  |  |  |   |  |                           |  |
| 19a. DATE OF OPERATION<br><b>9/22/78</b>  |  |   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>12/24/79</b>  |  |  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |   |  |                           |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. <b>19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)   |  |  |   |   |  |  |  |   |  |                           |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET <b>9/22/78</b> CITY OR TOWN <b>12/24/79</b> COUNTY <b></b> STATE <b></b>   |  |  |   |   |  |  |  |   |  |                           |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>12/24/79</b> to <b>12/24/79</b> , that (I) (we) lost saw the deceased alive on <b>12/24/79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |   |  |  |  |  |   |   |  |  |  |   |  |                           |  |
| 22b. SIGNATURE<br><b>Anthony F. Carozza</b> MD  |  |   |  | DEGREE <b>MD</b><br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  |  |   | 22c. DATE SIGNED<br><b>12/24/79</b>   |  |  |  |   |  |                           |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Anthony F. Carozza</b>  |  |   |  | 22e. ADDRESS<br><b>6000 Bellona Ave Balto Md.</b>  |  |  |   |   |  |  |  |   |  |                           |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY) <b>Burial</b>  |  | 23b. DATE<br><b>12/27/79</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Oak Lawn</b>  |  |  |   | 23d. LOCATION<br>CITY OR TOWN <b>Balto.</b> COUNTY <b></b> STATE <b>Md.</b> |  |  |  |   |  |                           |  |
| 24. FUNERAL DIRECTOR<br><b>Solimunek Funeral Home, Inc.</b>   |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>DEC 28 1979</b>  |  |  |   | 25b. REGISTRAR'S SIGNATURE<br><b>Anthony F. Carozza</b>                     |  |  |  |   |  |                           |  |





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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DHMH - 16 50M 7/77  
(VRA 15 (4))

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |                              |  |  |                                    |  |   |   |  |
|---|--|------------------------------|--|--|------------------------------------|--|---|---|--|
| 1. FOR<br>STATE<br>REGISTRAR  |  |                              | REG. NO. 7 9 3 0 6 0 2   |  |                                    |  |   |   |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |  |                              | FIRST MIDDLE LAST  |  |                                    | 2a. DATE OF DEATH MONTH DAY YEAR   |   |   | 2b. HOUR                                     |
| Charles A Seibold JR.   |  |                              |  |  |                                    | 12 29 79   |   |   | 12:59P M                                     |
| 3. SEX  |  | 4. RACE                      |  | 5. DATE OF BIRTH   |                                    | 6. AGE (IN YEARS LAST BIRTHDAY)  |   | 7. IF UNDER 1 YEAR  |  |
| Male  |  | Caucasian                    |  | MONTH DAY YEAR   |                                    | 75 YRS.  |   | IF UNDER 24 HRS.  |  |
| 10a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  | 7b. CITIZEN OF WHAT COUNTRY? |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                    | 9. BALTIMORE CITY OR COUNTY OF DEATH   |   |   |  |
| MD.   |  | US                           |  |  |                                    | Balto. City  |   | MD.   |  |
| 10. CITY OR TOWN OF DEATH   |  |                              | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |                                    | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                  |   | 12b. KIND OF BUSINESS OR INDUSTRY                                   |  |
| Balto. City   |  |                              | Sinai Hosp   |  |                                    | Retired  |   | W.C.A.O.  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  |                              | 13b. COUNTY  |  |                                    | 13c. CITY OR TOWN  |   | 13d. INSIDE CITY LIMITS?  |  |
| Md  |  |                              | Balto  |  |                                    | Pikesville   |   | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 14. FATHER'S NAME   |  |                              | 15. MOTHER'S MAIDEN NAME   |  |                                    | 13e. STREET ADDRESS  |   |   |  |
| FIRST MIDDLE LAST   |  |                              | FIRST MIDDLE LAST  |  |                                    | 122 Slade Ave 21208  |   |   |  |
| CHARLES A SEIBOLD SR.   |  |                              | HELEN FAIRLEY  |  |                                    |  |   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)   |  |                              | 16b. SOCIAL SECURITY NO.   |  |                                    | 17. INFORMANT ADDRESS  |   |   |  |
| No  |  |                              | 212-03-2584  |  |                                    | LILLIAN K. SEIBOLD SAME  |   |   |  |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <u>cardiopulmonary failure</u><br>1541<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:<br>DUE TO, OR AS A CONSEQUENCE OF (b) <u>Rectal carcinoma ± metastatic lesion</u><br>DUE TO, OR AS A CONSEQUENCE OF (c) _____<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): |  |                              |  |  |                                    |  |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| 19a. DATE OF OPERATION  |  |                              | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |                                    | 20a. AUTOPSY?  |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?      |  |
| 11-27-79  |  |                              | Rectal ca → diverting colostomy  |  |                                    | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |   | YES <input type="checkbox"/> NO <input type="checkbox"/>            |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |                              | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR   |  |                                    | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |   |   |  |
|   |  |                              | P.M. 19 79   |  |                                    |  |   |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  |                              | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  |                                    | 21f. LOCATION STREET   |   | CITY OR TOWN COUNTY STATE   |  |
|   |  |                              |  |  |                                    |  |   |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 11/19 19 79 to 12/29 19 79, that (I) (we) last saw the deceased alive on 12/29 19 79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |                              |  |  |                                    |  |   |   |  |
| 22b. PHYSICIAN'S NAME (TYPE OR PRINT)   |  |                              | 22c. ADDRESS   |  |                                    | 22d. SIGNATURE   |   | DEGREE  |  |
| GARY ADRIANO  |  |                              | 60 Breeze Br. St.  |  |                                    | Resident physician   |   | DATE SIGNED 12/29/79  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   |  |                              | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY |  | 23d. LOCATION CITY OR TOWN COUNTY STATE |   |  |
| Burial  |  |                              | 1-2-80   |  | DRUID RIDGE CEM.                   |  | Balto. Co. MD.                          |   |  |
| 24. FUNERAL DIRECTOR NAME   |  |                              |  |  | 25a. DATE REC'D. BY REGISTRAR      |  | 25b. REGISTRAR'S SIGNATURE              |   |  |
| NEWELL F.H. 1100 REISTERSTOWN RD  |  |                              |  |  | JAN 3 1980                         |  | [Signature]                             |   |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

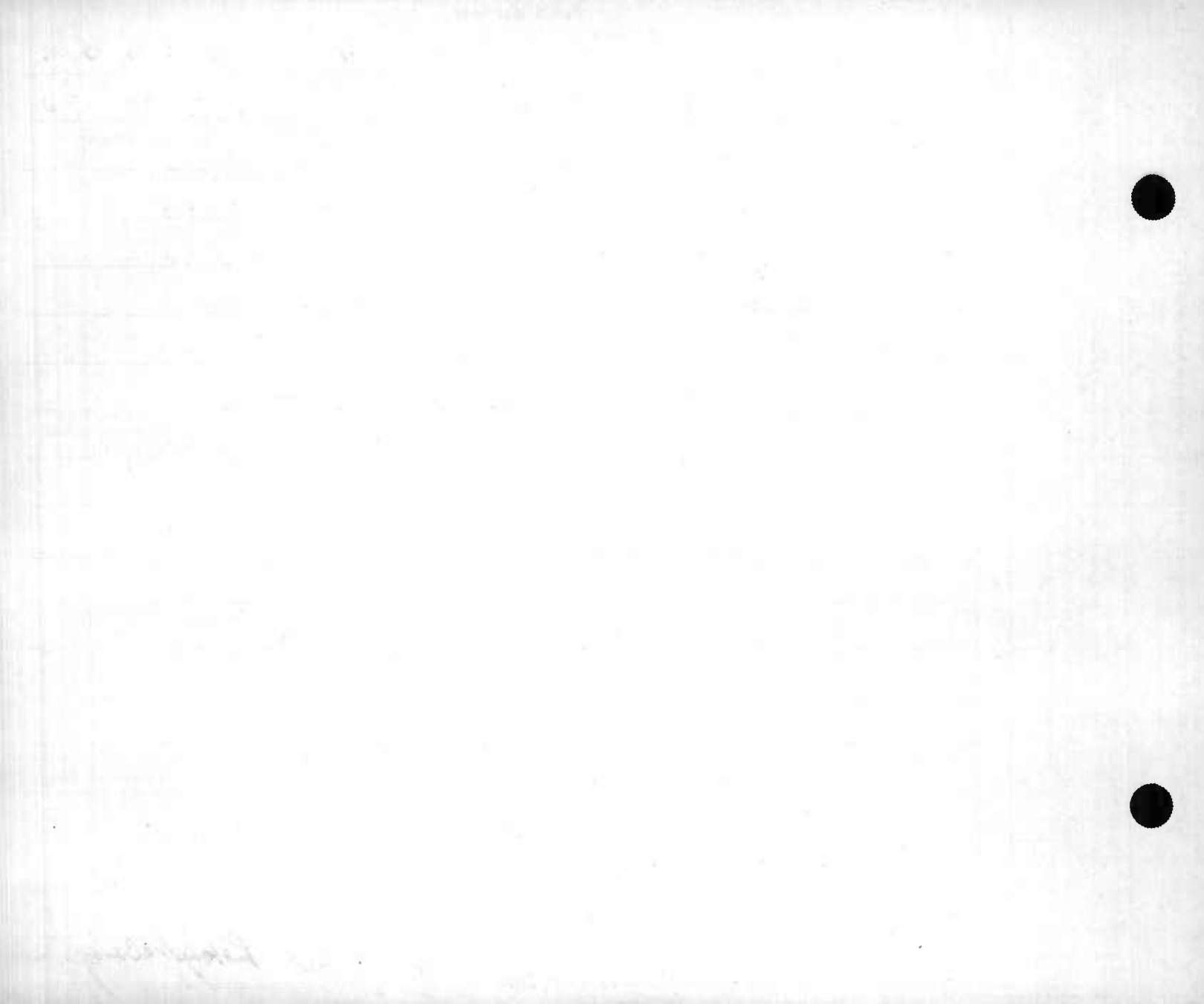
| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  |   |   |  |  |   |  | REG. NO. 7 9 3 0 6 0 3   |  |   |  |
|---|--|--|--|---|---|--|--|---|--|--|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br>Melvin T. Seidler   |  |  |  |   |   |  |  |   |  | 2a. DATE OF DEATH MONTH DAY YEAR<br>12 23 79   |  | 2b. HOUR<br>5:45a.m.                        |  |
| 3. SEX<br>male  |  | 4. RACE<br>White   |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>7-4-20   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>59 YRS.   |  | 7. IF UNDER 1 YEAR MONTHS DAYS  |  | 7b. IF UNDER 24 HRS. HOURS MIN.  |  |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Baltimore, Md.   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City, MD.                                |  |   |  |  |  |   |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Mercy Hospital |  |   |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Electrical Work-U.S.Govt. |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |  |  |   |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE Md. 13b. COUNTY --- 13c. CITY OR TOWN Baltimore   |  |  |  |   |   |  |  |   |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br>134 N. Decker Avenue |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>Joseph T. Seidler  |  |  |  |   | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Marie F. Witz |  |  |   |  |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>Yes  |  | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)<br>WW II  |  | 17. INFORMANT<br>Baltimore, Md. 21224.<br>Mrs. Marie F. Seidler-134 N. Decker   |   |  |  |   |  |  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Lactic Acidosis + Sepsis<br>2020<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) PANCYTOPENIA Hypocalcemia<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) II B nodular lymphoma                    |  |  |  |   |   |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>Ave  |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |  |  |   |   |  |  |   |  |  |  |   |  |
| 19a. DATE OF OPERATION<br>11/2/79   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br>Lymphoma - Ascites   |  |   |   | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>          |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |  |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |   |  |  |   |  |  |  |   |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |   |  |  |   |  |  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 10/22, 19 79, to 12/23, 19 79, that (I) (we) last saw the deceased alive on 12/23, 19 79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. |  |  |  |   |   |  |  |   |  |  |  |   |  |
| 22b. SIGNATURE<br>S. Scalia   |  |  |  | DEGREE  |   |  |  | 22c. DATE SIGNED<br>12/23/79  |  |  |  |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>S. Scalia  |  |  |  | 22e. ADDRESS<br>Mercy Hospital  |   |  |  |   |  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial   |  | 23b. DATE<br>12/26/79  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Parkwood Cemetery   |   | 23d. LOCATION CITY OR TOWN COUNTY STATE<br>Baltimore, Maryland                             |  |   |  |  |  |   |  |
| 24. FUNERAL DIRECTOR NAME<br>John E. McCall, Jr.<br>3000 E. Baltimore St.<br>Baltimore, Md. 21224   |  |  |  |   |   | 25a. DATE REC'D. BY REGISTRAR<br>DEC 27 1979   |  | 25b. REGISTRAR'S SIGNATURE<br>Patricia McCall   |  |  |  |   |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  |  |  |   |  |  |  |
|---|--|--|--|--|--|---|--|--|--|
| 1. FOR STATE REGISTRAR  |  | 7. REG. NO. 30604  |  |  |  |   |  |  |  |
| 1. DECEASED NAME (TYPE OR PRINT)  |  | FIRST MIDDLE LAST  |  | 2a. DATE OF DEATH MONTH DAY YEAR   |  | 2b. HOUR  |  |  |  |
| EDMUND J. SELIG sr.   |  |  |  | 12 29 79   |  | 3P  |  | M  |  |
| 3 SEX   |  | 4 RACE   |  | 5 DATE OF BIRTH MONTH DAY YEAR   |  | 6 AGE (IN YEARS LAST BIRTHDAY)                                      |  | 7. IF UNDER 1 YEAR IF UNDER 24 HRS           |  |
| male  |  | xxx White  |  | 4 21 09  |  | 70 YRS  |  | MONTHS DAYS HOURS MIN                        |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |  |  |  |
| Md.   |  | USA  |  |  |  | BALTIMORE   |  | MD.  |  |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)                                     |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |  | 12b. KIND OF BUSINESS OR INDUSTRY                                   |  |  |  |
| BALTIMORE   |  | GOOD SAWARITAN   |  | RETIRED  |  | Service Station   |  |  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  | 13a. STATE   |  | 13b. COUNTY  |  | 13c. CITY OR TOWN   |  | 13d. INSIDE CITY LIMITS?                     |  |
| Md.   |  | Baltimore  |  | Baltimore  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS                          |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST   |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)  |  | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)                |  | 17. INFORMANT ADDRESS                        |  |
| Edward Selig  |  | Agnes Bahr   |  | no   |  | 214-01-5659   |  | Mrs. Elizabeth L. Selig same                 |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:   |  | IMMEDIATE CAUSE (a)  |  | DUE TO, OR AS A CONSEQUENCE OF (b)   |  | DUE TO, OR AS A CONSEQUENCE OF (c)                                  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| 4413  |  | RUPTURED ABDOMINAL AORTIC ANEURYSM   |  | ATHEROSCLEROSIS  |  |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |  |  |  |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?      |  |  |  |
| 12-29-79  |  | RUPTURED ANEURYSM  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | YES <input type="checkbox"/> NO <input type="checkbox"/>            |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |   |  |  |  |
|   |  | P.M. 19  |  |  |  |   |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |   |  |  |  |
|   |  |  |  |  |  |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 12/29/79 19 to 12/29 19 79, that (I) (we) last saw the deceased alive on 12/29 19 79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  | 22b. SIGNATURE DEGREE  |  | 22c. DATE SIGNED   |  |   |  |  |  |
| Jeffrey E. Kremen MD  |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 12/29/79   |  |   |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  | 22e. ADDRESS   |  |  |  |   |  |  |  |
| JEFFREY E. KREMEN MD  |  | 2435 W. Belvedere Suite 21   |  |  |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE                             |  |  |  |
| Burial  |  | Jan. 2, 1980   |  | Moreland Park  |  | Baltimore Md.   |  |  |  |
| 24. FUNERAL DIRECTOR NAME   |  | ADDRESS  |  | 25a. DATE REC'D. BY REGISTRAR  |  | 25b. REGISTRAR'S SIGNATURE  |  |  |  |
| Leonard J. Ruck Inc. Baltimore, Maryland  |  |  |  | DEC 31 1979  |  | Jeffrey E. Kremen   |  |  |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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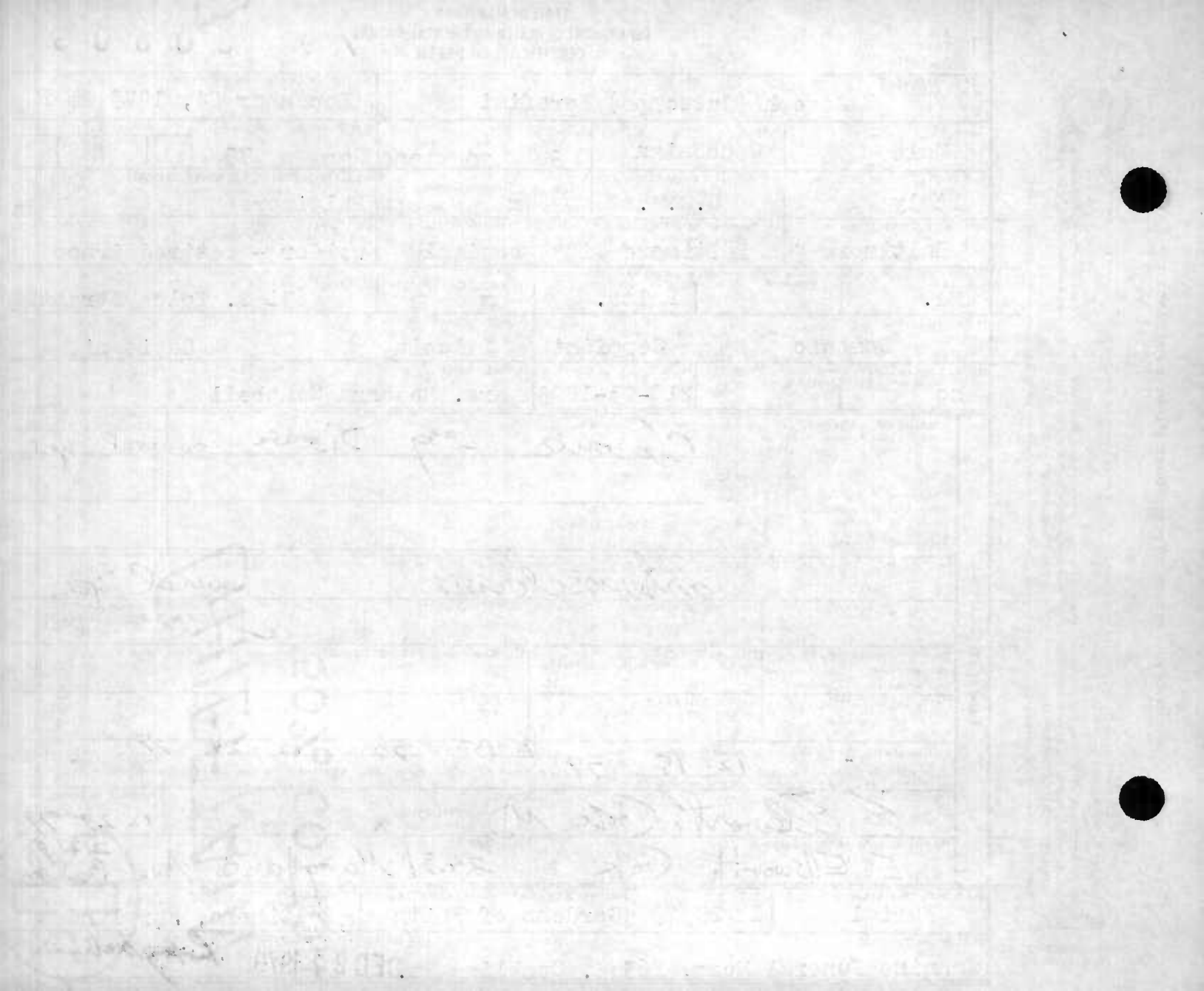
| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |   |   |                          |   |  |   |                     |
|--|--|---|---|---|--------------------------|---|--|---|---------------------|
| 1. FOR<br>STATE<br>REGISTRAR   |  |   | 7 9 3 0 6 0 5<br>REG. NO.                     |   |                          |   |  |   |                     |
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  |   | FIRST MIDDLE LAST                             |   |                          | 2a. DATE OF DEATH MONTH DAY YEAR                                    |  |   | 2b. HOUR<br>P M     |
| Joseph (Guiseppe) Serafini   |  |   |   |   |                          | December 24, 1979   |  |   | P                   |
| 3. SEX   |  | 4. RACE   |   | 5. DATE OF BIRTH  |                          | 6. AGE (IN YEARS LAST BIRTHDAY)                                     |  | IF UNDER 1 YEAR<br>MONTHS DAYS                                      |                     |
| Male   |  | Caucasian   |   | MONTH DAY YEAR<br>6 20 1900   |                          | 70 79 YRS.  |  |   |                     |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  | 7b. CITIZEN OF WHAT COUNTRY?  |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                          | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |  |   |                     |
| Italy  |  | U.S.A.  |   |   |                          | Baltimore City MD.  |  |   |                     |
| 10. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |   |   |                          | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)    |  | 12b. KIND OF BUSINESS OR INDUSTRY                                   |                     |
| Baltimore  |  | Baltimore City Hospital   |   |   |                          | welder - retired  |  | Armco   |                     |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  |   |   |   | 13d. INSIDE CITY LIMITS? |   | 13e. STREET ADDRESS  |   |                     |
| 13a. STATE<br>Md.  |  |   |   |   | 13b. COUNTY<br>Balto.    |   | 13c. CITY OR TOWN<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   | 631 S. Tolna Street |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST   |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST |   |                          |   |  |   |                     |
| Domenic Serafini   |  |   | Lucia Capitani                                |   |                          |   |  |   |                     |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)   |  |   | 16b. SOCIAL SECURITY NO.                      |   | 17. INFORMANT ADDRESS    |   |  |   |                     |
| no   |  |   | 219-03-1809                                   |   | Mrs. Rosanna Campbell    |   |  |   |                     |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Chronic Lung Disease</u><br>496-<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(c) _____<br>DUE TO, OR AS A CONSEQUENCE OF  |  |   |   |   |                          |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>several yrs.</u> |                     |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)<br><u>arteriosclerosis</u><br><u>several yrs.</u>  |  |   |   |   |                          |   |  |   |                     |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   |   |                          | 20a. AUTOPSY?   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?      |                     |
|  |  |   |   |   |                          | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | YES <input type="checkbox"/> NO <input type="checkbox"/>            |                     |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |                          |   |  |   |                     |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |                          |   |  |   |                     |
|  |  |   |   |   |                          |   |  |   |                     |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>1-15</u> , 19 <u>70</u> , to <u>12-24</u> , 19 <u>79</u> , that (I) (we) lost saw the deceased alive on <u>12-15</u> , 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |   |   |   |                          |   |  |   |                     |
| 22b. SIGNATURE<br><u>E. Ellsworth Cook MD</u>  |  |   |   |   |                          | DEGREE<br>MD  |  | 22c. DATE SIGNED<br>12 27 79  |                     |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>E. Ellsworth Cook   |  |   |   |   |                          | 22e. ADDRESS<br>2431 Maryland Ave. Balto                            |  |   |                     |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)   |  | 23b. DATE   |   | 23c. NAME OF CEMETERY OR CREMATORY  |                          | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE                          |  |   |                     |
| Burial   |  | 12/28/79  |   | Gardens of Faith  |                          | Baltimore, Maryland   |  |   |                     |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS   |  |   |   |   |                          | 25a. DATE REC'D. BY REGISTRAR                                       |  | 25b. REGISTRAR'S SIGNATURE  |                     |
| Zannino Funeral Home, 263 S. Conkling St   |  |   |   |   |                          | DEC 27 1979   |  | <u>Anthony M. Brady</u>   |                     |

MEDICAL CERTIFICATION

2  
9  
1

BP







TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DHMH - 17  
(VR A15 ME (5))  
30M 7/73

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 30606

|   |  |   |                                   |   |                     |
|---|--|---|-----------------------------------|---|---------------------|
| 1- STATE REGISTRAR  |  | 2a. DATE KNOWN OF DEATH                                       |                                   | 2b. HOUR  |                     |
| 1. DECEASED NAME (TYPE OR PRINT)  |  | 2c. DATE ESTIMATED  |                                   | 2d. HOUR  |                     |
| FIRST MIDDLE LAST   |  | MONTH DAY YEAR  |                                   | M   |                     |
| BERTHA IRENE SEYMOUR  |  | 12 19 1979  |                                   | 4:28 P.   |                     |
| 3. SEX  | 4. RACE  | 5. DATE OF BIRTH  | 6. AGE (IN YEARS)                 | 7. IF UNDER 1 YR.   | 7. IF UNDER 24 HRS. |
| female  | white  | 5/19/04   | 75 YRS.                           | MONTHS DAYS HOURS MIN.  | MONTH DAY YEAR      |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   | 7b. CITIZEN OF WHAT COUNTRY?                             | 8. MARRIED  | 8. NEVER MARRIED                  | 9. BALTIMORE CITY OR COUNTY OF DEATH  | 9. BALTIMORE CITY   |
| Md. Prince George County - U.S.A.   |  | WIDOWED   | DIVORCED                          | Baltimore City  |                     |
| 10. CITY OR TOWN OF DEATH   | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | 12b. KIND OF BUSINESS OR INDUSTRY |   |                     |
| Baltimore   | Church Home Hospital                                     | Saleslady   | Produce                           | Business  |                     |
| 13a. STATE  | 13b. CITY OR TOWN  | 13c. INSIDE CITY LIMITS?                                      | 13d. STREET ADDRESS               |   |                     |
| Md.   | Baltimore  | YES NO  | 522 N. Potomac St.                |   |                     |
| 14. FATHER'S NAME   | 15. MOTHER'S MAIDEN NAME                                 |   |                                   |   |                     |
| FIRST MIDDLE LAST   | FIRST MIDDLE LAST  |   |                                   |   |                     |
| Charles H. Cooksey  | Sallie Watson  |   |                                   |   |                     |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)  | 16b. SOCIAL SECURITY NO.                                 | 17. INFORMANT   | 322 Sweet Briar Court - Joppa Md. |   |                     |
| No  | 215-40-3437  | Donald C. Seymour, Sr.  |                                   |   |                     |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |  |   |                                   |   |                     |
| PART I DEATH WAS CAUSED BY:   |  |   |                                   |   |                     |
| IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease   |  |   |                                   |   |                     |
| DUE TO, OR AS A CONSEQUENCE OF  |  |   |                                   |   |                     |
| (b)   |  |   |                                   |   |                     |
| DUE TO, OR AS A CONSEQUENCE OF  |  |   |                                   |   |                     |
| (c)   |  |   |                                   |   |                     |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):   |  |   |                                   |   |                     |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?             |                                   | 20. AUTOPSY?  |                     |
|   |  |   |                                   | YES NO  |                     |
| 21a. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH   |  | 21b. TIME OF INJURY   |                                   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) |                     |
|   |  | HOUR A.M. MONTH DAY YEAR                                      |                                   |   |                     |
| 21d. INJURY OCCURRED  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)   |                                   | 21f. LOCATION   |                     |
| WHILE AT WORK NOT WHILE AT WORK   |  |   |                                   | STREET CITY OR TOWN COUNTY STATE  |                     |
| 22a. I certify that I took charge of the remains described above, held an Autopsy Inspection Inquiry, and in my opinion death resulted from: Natural causes Accident Suicide Homicide Undetermined manner |  |   |                                   |   |                     |
| death resulted from: Natural causes Accident Suicide Homicide Undetermined manner   |  |   |                                   |   |                     |
| ACTUAL SIGNATURE  |  | TITLE (SPECIFY)   |                                   | DATE SIGNED   |                     |
| Margarita A. Korell, M.D.   |  | Assistant   |                                   | 12/20/79  |                     |
| EXAMINER'S NAME (TYPE OR PRINT)   |  | ADDRESS   |                                   |   |                     |
| Margarita A. Korell, M.D.   |  | 111 Penn Street, Balto., MD 21201                             |                                   |   |                     |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   | 23b. DATE  | 23c. NAME OF CEMETERY OR CREMATORY                            | 23d. LOCATION                     |   |                     |
| Burial  | 12/24/79   | Meadowridge Memorial  | Park- Howard Cty., Md.            |   |                     |
| 24. FUNERAL DIRECTOR  |  | 25a. DATE REC'D. BY REGISTRAR                                 |                                   | 25b. REGISTRAR'S SIGNATURE  |                     |
| John A. Moran, Jr.  |  | DEC 26 1979   |                                   | [Signature]   |                     |
| NAME ADDRESS  |  |   |                                   |   |                     |
| 3000 E. Baltimore St.   |  |   |                                   |   |                     |
| Baltimore, Md. 21224  |  |   |                                   |   |                     |

DEC 26 1979

TO : DIRECTOR, FBI (100-374304)  
FROM : SAC, NEW YORK (100-100000) (P)  
SUBJECT: [Illegible]  
RE: [Illegible]  
[Illegible text follows, appearing to be a memorandum or report body.]

[Illegible text continues, appearing to be the main body of the document.]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed within 72 hours after death. The certificate is to be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, the certificate should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 18 is marked or item 19 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| Item 188 G539 1/29/80 dad STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |   |  |  |  |  |  |   | 79 30607<br>REG. NO.  |  |  |  |
|--|--|---|---|--|--|--|--|--|---|---|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT)<br>Fred Shackleford   |  |   |   |  | 2a. DATE OF DEATH MONTH DAY YEAR<br>12-12-79                     |  |  |  |   | 2b. HOUR<br>7:54 AM   |  |  |  |
| 3 SEX<br>male  |  | 4 RACE<br>Col   |   | 5. DATE OF BIRTH MONTH DAY YEAR<br>12 12 79  |  |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br>96 YRS.  |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.  |   |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Va  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |   | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore Md. MD.                             |  |   |   |  |  |  |
| 10 CITY OR TOWN OF DEATH<br>Baltimore Md.  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>J. L. Deaton Medical Center |   |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Caretaker           |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Caretaker  |   |  |  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>Md.  |  |   |   |  | 13b. COUNTY<br>Baltimore   |  | 13c. CITY OR TOWN<br>Baltimore   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                       |   |  |  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>Unknown   |  |   |   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Unknown            |  |  |  |   | 16. STREET ADDRESS<br>6115 S. Ches Street                       |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>No  |  |   |   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE YEAR OR DATES)<br>None |  | 17. INFORMANT ADDRESS<br>Margaret Fancan   |  |   |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>4321 IMMEDIATE CAUSE (a) SEPSIS<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) PNEUMONIA<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) CHRONIC<br>Patient transferred to Deaton from JHH where a basaloid hemangioma was excised |  |   |   |  |  |  |  |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>1 DAY<br>1 WEEK |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I.<br>CVA change in his neurologic status.   |  |   |   |  |  |  |  |  |   |   |  |  |  |
| 19a. DATE OF OPERATION   |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                    |  |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |  |   |   |  |  |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |   | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                 |  |  |   |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 12-4-79 to 12-12-79, that (I) (we) lost saw the deceased alive on 12-11-79, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.                              |  |   |   |  |  |  |  |  |   |   |  |  |  |
| 22b. SIGNATURE<br>M. J. Power M.D.   |  |   |   |  | DEGREE<br>M.D.   |  |  | 22c. DATE SIGNED<br>12-12-79                             |   |   |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>M. J. Power   |  |   |   |  | 22e. ADDRESS<br>6906 BONNIE RIDGE DR #1                          |  |  |  |   |   |  |  |  |
| 23a. BURIAL CREMATION-REMOVAL (SPECIFY)<br>Burial  |  |   | 23b. DATE<br>12-15-79   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Mt Calvary                 |  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br>Baltimore Md. |   |   |  |  |  |
| 24. FUNERAL DIRECTOR NAME<br>L. J. Carroll   |  |   |   |  | ADDRESS<br>1712 North  |  | 25a. DATE REC'D. BY REGISTRAR<br>DEC 27 1979   |  | 25b. REGISTRAR'S SIGNATURE<br>R. J. McCreedy  |   |  |  |  |



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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 2 should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |   |   |  |  |   |   |                                      |  |
|---|--|--|---|---|--|--|---|---|--------------------------------------|--|
| 1. FOR STATE REGISTRAR  |  |  |   |   |  |  |   |   |                                      |  |
| 1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br>Patricia Ann Shafer  |  |  |   |   | 2a. DATE OF DEATH MONTH DAY YEAR<br>12 2 79              |  | 2b. HOUR<br>0545 <sup>PM</sup>  |   |                                      |  |
| 3 SEX<br>Female   |  | 4 RACE<br>White  |   | 5 DATE OF BIRTH MONTH DAY YEAR<br>4 25 1948   |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br>31 YRS   |   | 7 IF UNDER 1 YEAR IF UNDER 24 HRS<br>MONTHS DAYS HOURS MIN.   |                                      |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  |   | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore MD                                  |   |   |                                      |  |
| 10 CITY OR TOWN OF DEATH<br>Baltimore   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Shock Trauma Hosp. |   |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Secretary           |   | 12b. KIND OF BUSINESS OR INDUSTRY   |                                      |  |
| 13a. STATE<br>Maryland  |  |  | 13b. COUNTY<br>Carroll  |   | 13c. CITY OR TOWN<br>Mt. Airy                            |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 13e. STREET ADDRESS<br>4806 Ridge RD |  |
| 14 FATHER'S NAME FIRST MIDDLE LAST<br>Flydd Myers   |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Margaret Weiger |   |  |  |   |   |                                      |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>No   |  |  | 16b. SOCIAL SECURITY NO.<br>212-50-8796                       |   | 17 INFORMANT ADDRESS<br>4806 Ridge RD., Robert W. Shafer |  |   |   |                                      |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Subarachnoid Haemorrhage. 430- DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c)  |  |  |   |   |  |  |   |   |                                      |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |  |   |   |  |  |   |   |                                      |  |
| 19a. DATE OF OPERATION<br>12-1-79   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br>Increased intracranial pressure.   |   |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                      |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |   |   |                                      |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |  |   |   |                                      |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 12/1/79 to 12/2/79, that (I) (we) last saw the deceased alive on 12/2/79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. |  |  |   |   |  |  |   |   |                                      |  |
| 22b. SIGNATURE (Signature) DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>  |  |  |   |   |  | 22c. DATE SIGNED<br>12-2-79  |   |   |                                      |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>DR. CONNY.   |  |  |   |   |  | 22e. ADDRESS<br>22. SOUTH GREENE ST. BALTIMORE MD                                    |   |   |                                      |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Cremation  |  | 23b. DATE<br>Dec. 3, 1979  |   | 23c. NAME OF CEMETERY OR CREMATORY<br>Westview  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br>Baltimore, Md.                            |   |   |                                      |  |
| 24 FUNERAL DIRECTOR NAME<br>Olin L. Molesworth, Damascus, Md.   |  |  |   |   |  | 25a. DATE REC'D. BY REGISTRAR<br>DEC 6 1979  |   | 25b. REGISTRAR'S SIGNATURE<br>(Signature)   |                                      |  |

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FOR  
1 - STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

7 9 3 0 6 0 9

REG. NO.

|   |  |  |   |   |   |
|---|--|--|---|---|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>ZAKY - SHALABY</b>   |  |  | 2a. DATE OF DEATH<br><b>11-28-79</b>  |   | 2b. HOUR<br><b>1:00A</b>                        |
| 3. SEX<br><b>MALE</b>   | 4. RACE<br><b>EGYPTIAN</b>   | 5. DATE OF BIRTH<br>MONTH <b>10</b> - DAY <b>17</b> - YEAR <b>90</b>   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>82</b> YRS.                                 | 7. IF UNDER 1 YEAR<br>MONTHS <b>0</b> DAYS <b>0</b> HOURS <b>0</b> MIN.   |   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>EGYPT</b>   | 7b. CITIZEN OF WHAT COUNTRY?<br><b>?</b>   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTO CITY</b> MD                      |   |   |
| 10. CITY OR TOWN OF DEATH<br><b>BALTO</b>   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>JOHNS HOPKINS HOSP</b> |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>UNEMP.</b> |   | 12b. KIND OF BUSINESS OR INDUSTRY               |
| 13a. STATE<br><b>Maryland</b>   |  | 13b. COUNTY<br><b>---</b>  | 13c. CITY OR TOWN<br><b>Baltimore</b>   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                       | 13e. STREET ADDRESS<br><b>201 N. Broadway</b>   |
| 14. FATHER'S NAME<br>FIRST <b>---</b> MIDDLE <b>Unknown</b> LAST <b>---</b>   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>---</b> MIDDLE <b>Unknown</b> LAST <b>---</b>   |   |   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>219-01-6369</b>  |   | 17. INFORMANT<br><b>Zachary Shalaby</b> ADDRESS <b>Route 2, Box 100 A</b>   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CARDIO PULMONARY ARREST</b>   |  |  |   |   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |
| 1889<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF (b)<br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>LOW GRADE CARCINOMA OF BLADDER</b>  |  |  |   |   |   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).<br><b>CONGESTIVE HEART FAILURE, THROMBOPHLEBITIS.</b>  |  |  |   |   |   |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   | 19c. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 20b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |   | 20c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |   |
| 21a. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21b. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |   | 21c. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |
| 22. I certify that (I) (this hospital) attended the deceased from <b>9/19</b> 19 <b>79</b> , to <b>11/28/79</b> 19 <b>79</b> , that (I) (we) last saw the deceased alive on <b>11/27</b> 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) did not view the body after death, so state.) |  |  |   |   |   |
| 22a. SIGNATURE<br><b>A. McCullough</b>  |  | DEGREE<br><b>MD</b>  |   | 22b. DATE SIGNED<br><b>11/28</b>  |   |
| 22c. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>ANDREW R. McCULLOUGH</b>  |  | 22d. ADDRESS<br><b>DEPT OF UROLOGY - J.H.H.</b>  |   |   |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Cremation</b>  |  | 23b. DATE<br><b>12-1-79</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Green Mount Crematory</b>  |   |
| 23d. LOCATION<br>CITY OR TOWN<br><b>Baltimore</b>   |  | COUNTY<br><b>---</b>   |   | STATE<br><b>Maryland</b>  |   |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Lilly &amp; Zeiler Inc.</b>  |  | ADDRESS<br><b>1901 Eastern Ave.</b>  |   | 25a. DATE REC'D. BY REGISTRAR<br><b>DEC 3 1979</b>  |   |
|   |  | 25b. REGISTRAR'S SIGNATURE<br><b>Anthony Kebrudy</b>   |   |   |   |

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 3 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.



STANDARD FORM NO. 64  
MAY 1962 EDITION  
GSA GEN. REG. NO. 27

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STANDARD FORM NO. 64  
MAY 1962 EDITION  
GSA GEN. REG. NO. 27

STANDARD FORM NO. 64  
MAY 1962 EDITION  
GSA GEN. REG. NO. 27



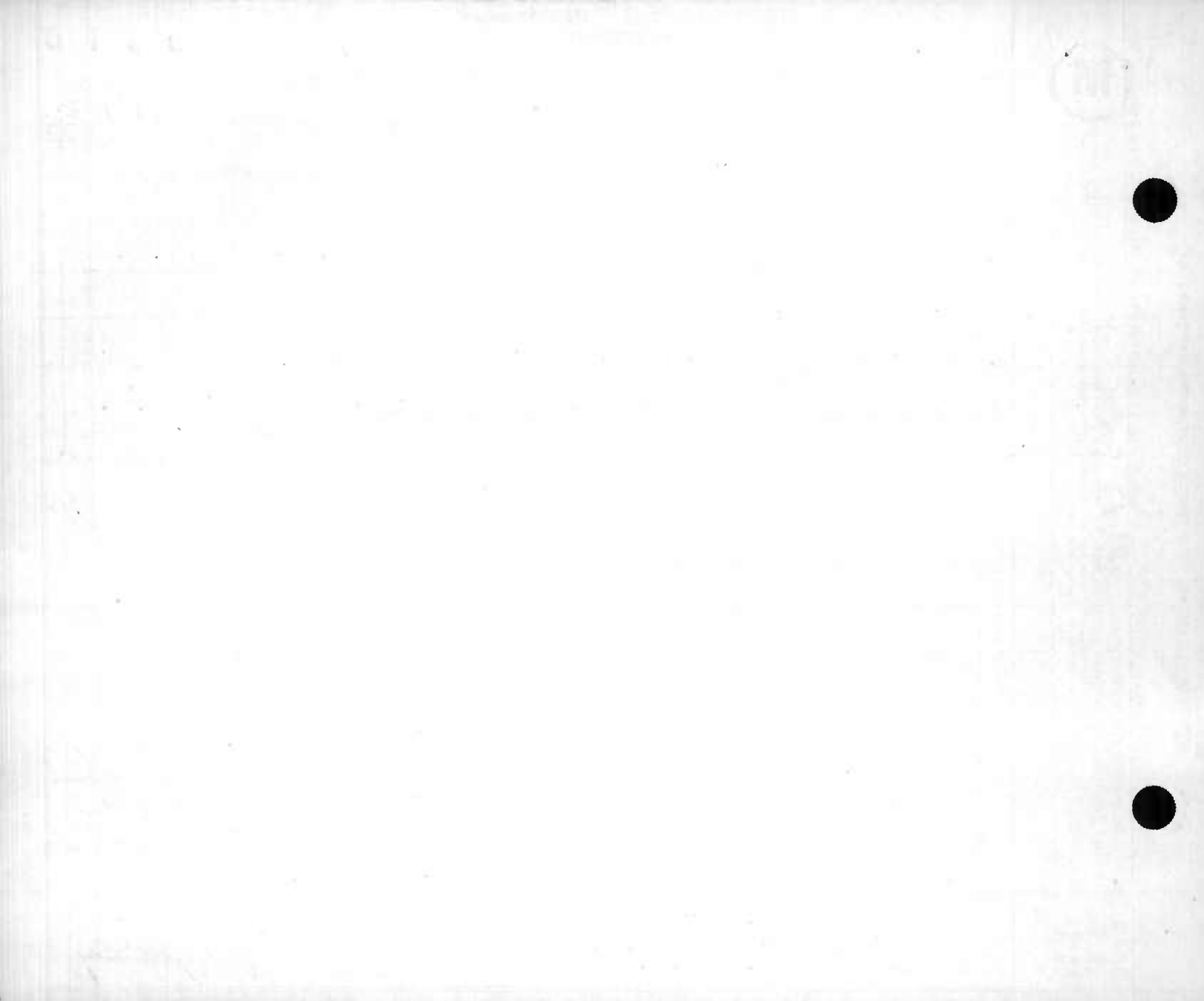


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |   |   |   |  |   |  |                             |
|--|--|--|---|---|---|--|---|--|-----------------------------|
| 1. FOR STATE REGISTRAR   |  |  |   |   | 7 9 3 0 6 1 0<br>REG. NO.                                   |  |   |  |                             |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>IDA</b>  |  |  | FIRST<br><b>SHANE</b>   |   |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>12-19-79</b>   |   |  | 2b. HOUR<br><b>10 25 AM</b> |
| 3 SEX<br><b>Female</b>   |  | 4 RACE<br><b>CAUCASIAN</b>   |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>05-20-96</b>   |   | 6 AGE (IN YEARS LAST BIRTHDAY)<br><b>83</b>  |   | 7. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN<br><b>YRS.</b>   |                             |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>RUSSIA</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTO. CITY</b>   |   |  |                             |
| 10. CITY OR TOWN OF DEATH<br><b>BALTO. CITY</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>LEVINDALE GERIATRIC CENTER</b> |   |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>DRESSMAKER</b>  |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>CLOTHING</b>   |                             |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>MD.</b>   |  | 13b. COUNTY<br><b>BALTO</b>  |   | 13c. CITY OR TOWN<br><b>BALTIMORE</b>   |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |   | 13e. STREET ADDRESS<br><b>3201 VANCE RD. #21111</b>  |                             |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>JOSEPH</b>  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>LEAH</b>                      |   |   | 16. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>NO</b>                               |   |  |                             |
| 16b. SOCIAL SECURITY NO<br><b>080-18-3008</b>  |  |  | 17. INFORMANT<br><b>JOSEPH SHANE</b> ADDRESS<br><b>3201 VANCE RD. MONKTON, MD</b> |   |   |  |   |  |                             |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <b>Lobar pneumonia</b><br>4870<br>Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause lost<br>(b) <b>Influenza</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>10 days</b><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>1 week</b> |  |  |   |   |   |  |   |  |                             |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):   |  |  |   |   |   |  |   |  |                             |
| 19a. DATE OF OPERATION   |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                  |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                             |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>                 |   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |   |  |                             |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)            |   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |   |  |                             |
| 22. I certify that (I) (this hospital) attended the deceased from <b>12/19</b> 19 <b>76</b> , to <b>12/19</b> 19 <b>79</b> , that (I) (we) last saw the deceased alive on <b>12/19</b> 19 <b>76</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes noted above.  |  |  |   |   |   |  |   |  |                             |
| 22a. SIGNATURE<br><b>Steven Levenson M.D.</b>  |  |  | DEGREE<br><b>M.D.</b>   |   |   | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |   | 22b. DATE SIGNED<br><b>12/19/79</b>  |                             |
| 22c. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Steven Levenson</b>  |  |  | 22e. ADDRESS<br><b>LEVINDALE - BALTO., MD 21215</b>                               |   |   |  |   |  |                             |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>BURIAL</b>   |  |  | 23b. DATE<br><b>DEC. 20, 1979</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>WORKMEN CIRCLE</b> |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>BALTIMORE MARYLAND</b> |  |                             |
| 24. FUNERAL DIRECTOR<br><b>SOL LEVINSON &amp; BROS., INC.</b>  |  |  | 24b. ADDRESS<br><b>6010 REISTERSTOWN RD. BALTO., MD 21215</b>                     |   | 25a. DATE REC'D. BY REGISTRAR<br><b>DEC 27 1979</b>         |  | 25b. REGISTRAR'S SIGNATURE<br><b>Fristay</b>                            |  |                             |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, the funeral director should be detected for use as the burial-transit permit. Then please remove carbon copy. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  | 79 30611<br>REG. NO.   |  |  |  |
|--|--|--|--|--|--|--|--|
| 1. FOR STATE REGISTRAR   |  |  |  |  |  |  |  |
| 1. DECEASED NAME (TYPE OR PRINT) <b>Hazel M Sharp</b>  |  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR <b>DECEMBER 15, 1979</b>  |  |  |  |
| 3. SEX <b>female</b>   |  |  |  | 2b. HOUR <b>8:30</b> P   |  |  |  |
| 4. RACE <b>caucasian</b>   |  |  |  | 5. DATE OF BIRTH MONTH DAY YEAR <b>Nov. 14, 1920</b>   |  |  |  |
| 6. AGE (IN YEARS LAST BIRTHDAY) <b>59</b> YRS.   |  |  |  | 7. IF UNDER 1 YEAR MONTHS DAYS   |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>  |  |  |  | 7b. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>   |  |  |  |
| 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>   |  |  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY</b> MD.   |  |  |  |
| 10. CITY OR TOWN OF DEATH <b>Baltimore</b>   |  |  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>THE JOHNS HOPKINS HOSPITAL</b> |  |  |  |
| 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>homemaker</b>   |  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |  |  |
| 13a. STATE <b>Maryland</b>   |  |  |  | 13b. COUNTY <b>Talbot</b>  |  |  |  |
| 13c. CITY OR TOWN <b>Newcomb</b>   |  |  |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  |  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST <b>unknown</b>   |  |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Virginia Mae Sharp</b>   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>no</b>  |  |  |  | 16b. SOCIAL SECURITY NO <b>219-62-7326</b>   |  |  |  |
| 17. INFORMANT ADDRESS <b>Virginia M. Kilmon Newcomb, Md.</b>   |  |  |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <b>cardio pulmonary arrest</b>   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |  |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>uterine cancer</b>  |  |  |  |  |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF (c)   |  |  |  |  |  |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  |  |
| 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>                  |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>  |  |  |  |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |  |  |  |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK   |  |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  |  |  |
| 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |  |  |  |  |  |  |
| 22. I certify that (I) (this hospital) attended the deceased from <b>12/10</b> , 19 <b>79</b> , to <b>12/15</b> , 19 <b>79</b> , that (I) (we) last saw the deceased alive on <b>12/15</b> , 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |  |  |
| 22a. SIGNATURE <b>Frank R. Witter</b>  |  |  |  | 22b. DATE SIGNED <b>12/15/79</b>   |  |  |  |
| 22c. DEGREE <b>MD</b>  |  |  |  | 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Frank R. Witter</b>   |  |  |  |
| 22e. ADDRESS <b>Johns Hopkins Hospital, Baltimore, Md.</b>   |  |  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>  |  |  |  | 23b. DATE <b>12-18-1979</b>  |  |  |  |
| 23c. NAME OF CEMETERY OR CREMATORY <b>Olivet Cemetery</b>  |  |  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE <b>St. Michaels, Talbot, Md.</b>   |  |  |  |
| 24. FUNERAL DIRECTOR NAME <b>Newnam Funeral Home</b> ADDRESS <b>Easton, Md.</b>  |  |  |  | 25. DATE REG'D BY REGISTRAR <b>DEC 20 1979</b>   |  |  |  |
| 26. REGISTRAR'S SIGNATURE  |  |  |  |  |  |  |  |

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FOR  
1- STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 30612

|  |  |  |  |   |  |   |  |                            |  |  |  |   |  |
|--|--|--|--|---|--|---|--|----------------------------|--|--|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  | FIRST  |  | MIDDLE  |  | LAST  |  | 2a. DATE KNOWN<br>OF DEATH |  | <input checked="" type="checkbox"/> MONTH DAY YEAR |  | 2b. HOUR  |  |
| WILLIE   |  | F.   |  |   |  | Sharp,<br>(SHARPE,) JR.   |  | 12-18                      |  | 19 79  |  | M   |  |
| 3. SEX   |  | 4. RACE  |  | 5. DATE OF BIRTH  |  | 6. AGE (IN YEARS)   |  | IF UNDER 1 YR.             |  | IF UNDER 24 HRS.                                   |  | 2c. DATE<br>PRONOUNCED<br>DEAD                                      |  |
| male   |  | black  |  | 4 22 45   |  | 34 YRS.   |  |                            |  |  |  | 4:30 P M  |  |
| 7a. BIRTHPLACE (STATE OR<br>FOREIGN COUNTRY)   |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |  |                            |  |  |  |   |  |
| Virginia   |  | U. S. A.   |  | WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>                    |  | Baltimore City  |  |                            |  |  |  | MD.   |  |
| 10. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 12a. USUAL OCCUPATION (TYPE OF WORK<br>FOR MOST OF WORKING LIFE)                      |  | 12b. KIND OF BUSINESS<br>OR INDUSTRY                                |  |                            |  |  |  |   |  |
| Baltimore  |  | Baltimore City Hospital  |  |   |  |   |  |                            |  |  |  |   |  |
| 13a. STATE   |  | 13b. COUNTY  |  | 13c. CITY OR TOWN   |  | 13d. INSIDE CITY LIMITS?  |  | 13e. STREET ADDRESS        |  |  |  |   |  |
| Maryland   |  | Balto  |  | Baltimore   |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 2009 Paulette Road Apt-1   |  |  |  |   |  |
| 14. FATHER'S NAME  |  | MIDDLE   |  | LAST  |  | 15. MOTHER'S MAIDEN NAME  |  | MIDDLE                     |  | LAST   |  |   |  |
| Willie   |  |  |  | Sharp, Sr.  |  | Mary  |  |                            |  | Myles  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)  |  | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT   |  | ADDRESS   |  |                            |  |  |  |   |  |
| No   |  | 217-40-6066  |  | Willie Sharp, Sr.   |  | 2009 Paulette Road  |  |                            |  |  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Subdural hematoma</u><br>888-<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which<br>gave rise to immediate<br>cause (a) stating the under-<br>lying cause last.<br>(b)<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)   |  |  |  |   |  |   |  |                            |  |  |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH.                    |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).  |  |  |  |   |  |   |  |                            |  |  |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |  |   |  |   |  |                            |  |  |  | 20. AUTOPSY?  |  |
|  |  |  |  |   |  |   |  |                            |  |  |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input checked="" type="checkbox"/> OR<br>CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |  | 21b. TIME OF INJURY<br>HOUR AM MONTH DAY YEAR  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)         |  |   |  |                            |  |  |  |   |  |
|  |  | 6:30 AM 12-12 19 79  |  | subject fell striking head  |  |   |  |                            |  |  |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME,<br>STREET, FACTORY, FARM, ETC.)   |  | 21f. LOCATION<br>STREET   |  | CITY OR TOWN  |  | COUNTY                     |  | STATE  |  |   |  |
|  |  | street   |  | Chestnut Street   |  | Baltimore, Maryland   |  |                            |  |  |  |   |  |
| 22a. I certify that I took charge of the remains described above, held on <u>Autopsy</u> <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion<br>death resulted from: <u>Natural causes</u> <input type="checkbox"/> , <u>Accident</u> <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . |  |  |  |   |  |   |  |                            |  |  |  |   |  |
| ACTUAL<br>SIGNATURE  |  | TITLE (SPECIFY)  |  | DATE<br>SIGNED  |  |   |  |                            |  |  |  |   |  |
| <i>H. Guard</i>  |  | M.D. Assistant   |  | 12/19/79  |  |   |  |                            |  |  |  |   |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT)   |  | ADDRESS  |  |   |  |   |  |                            |  |  |  |   |  |
| Hormez R. Guard, M.D.  |  | 111 Penn Street  |  |   |  |   |  |                            |  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)   |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY  |  | 23d. LOCATION<br>CITY OR TOWN                                       |  | COUNTY                     |  | STATE  |  |   |  |
| Burial   |  | 12/22/1979   |  | Church Cemetery   |  | Gouchland Co.   |  | Virginia                   |  |  |  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME   |  | ADDRESS  |  | 25a. DATE REC'D. BY REGISTRAR   |  | 25b. REGISTRAR'S SIGNATURE  |  |                            |  |  |  |   |  |
| Wm. C. March F/H   |  | 1101 East North Avenue   |  | DEC 20 1979   |  | <i>Robert M. ...</i>  |  |                            |  |  |  |   |  |



3:

*Handwritten signature*

DEC 20 1978

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| 1. FOR STATE REGISTRAR   |  | DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |   | 7 9 30613  |  |
|--|--|--|---|--|--|
| 1. DECEASED NAME (TYPE OR PRINT)   |  | 2a. DATE OF DEATH  |   | 2b. HOUR   |  |
| Margaret R. Shepard  |  | Dec. 10, 1979  |   | 12:38 A.M.   |  |
| 3. SEX   | 4. RACE  | 5. DATE OF BIRTH   | 6. AGE (IN YEARS LAST BIRTHDAY)                                     |  |  |
| Female   | Cauc.  | 06 04 18   | 61 YRS.   |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  | 7b. CITIZEN OF WHAT COUNTRY?   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |  |  |
| Cleveland, O.  | U.S.A.   |  | Hartford Balto. City MD.  |  |  |
| 10. CITY OR TOWN OF DEATH  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)       |  | 12b. KIND OF BUSINESS OR INDUSTRY                              |
| Balto, Md.   | Md. Shack Trauma Hospital  |  | RET - Factory work  |  | 65   |
| 13a. STATE   |  | 13b. COUNTY  | 13c. CITY OR TOWN   | 13d. INSIDE CITY LIMITS?   | 13e. STREET ADDRESS  |
| Md   | Hartford   | Jarrettsville  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 4117 Federal Hill Rd.  |  |
| 14. FATHER'S NAME  |  | 15. MOTHER'S MAIDEN NAME   |   |  |  |
| William Roche  |  | Elizabeth O'Brien  |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)  |  | 16b. SOCIAL SECURITY NO.   | 17. INFORMANT   |  |  |
| NO   |  | 284-09-8218  | Daughter (Mary E. Shepard)  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY:  |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                   |
| IMMEDIATE CAUSE (a) cardiac arrest   |  |  |   |  |  |
| 431- DUE TO, OR AS A CONSEQUENCE OF  |  |  |   |  |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.   |  |  |   |  |  |
| (b) cerebrovascular hemorrhage   |  |  |   |  |  |
| DUE TO, OR AS A CONSEQUENCE OF   |  |  |   |  |  |
| (c)  |  |  |   |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |  |   |  |  |
|  |  |  |   |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   | 20a. AUTOPSY?  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |
| 0  |  | 0  |   | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            | YES <input type="checkbox"/> NO <input type="checkbox"/>       |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |
|  |  | HOUR A.M. MONTH DAY YEAR   |   |  |  |
|  |  | P.M. 19  |   |  |  |
| 21d. INJURY OCCURRED   |  | 21e. PLACE OF INJURY   |   | 21f. LOCATION  |  |
| WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |   | STREET CITY OR TOWN COUNTY STATE   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from Dec 8, 1979, to Dec 10, 1979, that (I) (we) last saw the deceased alive on Dec 10, 1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |   |  |  |
| 22b. SIGNATURE   |  | DEGREE   |   | 22c. DATE SIGNED   |  |
| MD. Colm   |  |  |   | 10/10/79   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  | 22e. ADDRESS   |   |  |  |
| Colony, M.D.   |  | 6026 River Meadow, Col. Md 21045   |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |  | 23b. DATE  | 23c. NAME OF CEMETERY OR CREMATORY                                  |  | 23d. LOCATION  |
| Burial   |  | 12/13/79   | Dulaney Valley  |  | Cockeysville, Balto. MD  |
| 24. FUNERAL DIRECTOR NAME  |  | 25a. DATE REC'D. BY REGISTRAR  |   | 25b. REGISTRAR'S SIGNATURE   |  |
| Duda-Ruck, Inc.  |  | DEC 14 1979  |   | Anthony McCready   |  |
| 7922 Wise Avenue, Dundalk, MD 21222  |  |  |   |  |  |

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

7930614

REG. NO.

1- FOR  
STATE  
REGISTRAR

|  |                         |  |  |   |  |
|--|-------------------------|--|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <i>May E. Shepard</i>  |                         |  | 2a. DATE OF DEATH MONTH DAY YEAR <i>12-12-79</i> |   | 2b. HOUR <i>5<sup>10</sup> P.M.</i>                                |
| 3. SEX<br><i>Female</i>  | 4. RACE<br><i>White</i> | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><i>8-8-1892</i>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><i>87</i> YRS.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><i>Baltimore, Md.</i>   |                         | 7b. CITIZEN OF WHAT COUNTRY?<br><i>U.S.A.</i>  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><i>Balto. City</i> MD.                                  |  |
| 10. CITY OR TOWN OF DEATH<br><i>Balto</i>  |                         | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><i>Key Circle Hospice</i> |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><i>House wife</i>           |  |
| 13a. STATE<br><i>Maryland</i>  |                         | 13b. COUNTY  | 13c. CITY OR TOWN<br><i>Baltimore</i>            | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><i>John --- Schminke</i>   |                         | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><i>Mary --- Geglein</i>   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><i>No</i>  |                         | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><i>218-10-2367D</i>   |  | 17. INFORMANT ADDRESS<br><i>Mr. Charles Soistman, 9712 Liberty Rd., 21133</i>                   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY.<br>IMMEDIATE CAUSE (a) <i>Anemia Sec.</i><br><i>2859</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost |                         |  |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><i>several yrs</i> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><i>ASCVD &amp; Chronic Brain Syndrome several yrs</i>   |                         |  |  |   |  |
| 19a. DATE OF OPERATION   |                         | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |                         |  |  |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |                         | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |                         | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>3-13-73</i> , to <i>12-12-79</i> , that (I) (we) lost saw the deceased alive on <i>12-12-79</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                                 |                         |  |  |   |  |
| 22b. SIGNATURE<br><i>E. Ellsworth Cook M.D.</i>  |                         |  |  | 22c. DATE SIGNED<br><i>12-13-79</i>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><i>E. Ellsworth Cook</i>  |                         |  |  | 22e. ADDRESS<br><i>2431 Md. Ave.</i>  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><i>Burial</i>  |                         | 23b. DATE<br><i>12/17/79</i>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><i>Lake View Memorial Pk</i>                              |  |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><i>Sykesville, Carroll, Maryland</i>   |                         |  |  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><i>Loring Byers Funeral Directors P.A.</i><br><i>8728 Liberty Road, Randallstown, Md. 21133</i>  |                         |  |  | 25a. DATE REC'D. BY REGISTRAR<br><i>DEC 18 1979</i>   |  |
|  |                         |  |  | 25b. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>  |  |





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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

7 9 3 0 6 1 5

REG. NO.

|  |  |                                  |   |   |                                   |                              |  |                                      |     |      |            |
|--|--|----------------------------------|---|---|-----------------------------------|------------------------------|--|--------------------------------------|-----|------|------------|
| 1. FOR STATE REGISTRAR   |  | 1. DECEASED NAME (TYPE OR PRINT) |   | FIRST   | MIDDLE                            | LAST                         | 2a. DATE OF DEATH  | MONTH                                | DAY | YEAR | 2b. HOUR   |
|  |  | JUDGE JOSEPH SHERBOW             |   |   |                                   |                              | December 16, 1979  |                                      |     |      | 12:55 A.M. |
| 3. SEX   | 4. RACE  | 5. DATE OF BIRTH                 | 6. AGE (IN YEARS LAST BIRTHDAY)                               | 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)                           |                                   | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH |     |      |            |
| MALE   | CAUCASIAN  | MAY 1, 1901                      | 78 YRS.   | MARYLAND  |                                   | USA                          |  | BALTIMORE CITY                       |     | MD   |            |
| 10. CITY OR TOWN OF DEATH  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |                                  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) |   | 12b. KIND OF BUSINESS OR INDUSTRY |                              |  |                                      |     |      |            |
| BALTIMORE  | SINAI HOSPITAL   |                                  | ATTORNEY  |   | AT LAW                            |                              |  |                                      |     |      |            |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  | 13b. COUNTY                      | 13c. CITY OR TOWN   | 13d. INSIDE CITY LIMITS?  | 13e. STREET ADDRESS               |                              |  |                                      |     |      |            |
| MARYLAND   |  |                                  | BALTIMORE   | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 6300 Red Cedar Pl. APT 408        |                              |  |                                      |     |      |            |
| 14. FATHER'S NAME  |  | 15. MOTHER'S MAIDEN NAME         |   |   |                                   |                              |  |                                      |     |      |            |
| THEODORE SHERBOW   |  | ESTHER GROLLMAN                  |   |   |                                   |                              |  |                                      |     |      |            |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)  |  | 16b. SOCIAL SECURITY NO.         |   | 17. INFORMANT   |                                   |                              |  |                                      |     |      |            |
| NO   |  | 218-18-9652                      |   | MRS. SARA SHERBOW   |                                   | APT. 408                     |  |                                      |     |      |            |
|  |  |                                  |   | 6300 RED CEDAR PLACE. BALTO., MD 21209                              |                                   |                              |  |                                      |     |      |            |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY:  |  |                                  |   |   |                                   |                              |  |                                      |     |      |            |
| IMMEDIATE CAUSE (a) <u>Carcinoma of stomach &amp; liver</u>  |  |                                  |   |   |                                   |                              |  |                                      |     |      |            |
| DUE TO, OR AS A CONSEQUENCE OF (b) <u>Metastasis</u>   |  |                                  |   |   |                                   |                              |  |                                      |     |      |            |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>ASCUD</u>  |  |                                  |   |   |                                   |                              |  |                                      |     |      |            |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).   |  |                                  |   |   |                                   |                              |  |                                      |     |      |            |
| 19a. DATE OF OPERATION   |  |                                  |   |   |                                   |                              |  |                                      |     |      |            |
| 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |                                  |   |   |                                   |                              |  |                                      |     |      |            |
| 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>   |  |                                  |   |   |                                   |                              |  |                                      |     |      |            |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>  |  |                                  |   |   |                                   |                              |  |                                      |     |      |            |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |                                  |   |   |                                   |                              |  |                                      |     |      |            |
| 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19   |  |                                  |   |   |                                   |                              |  |                                      |     |      |            |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |                                  |   |   |                                   |                              |  |                                      |     |      |            |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |                                  |   |   |                                   |                              |  |                                      |     |      |            |
| 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  |                                  |   |   |                                   |                              |  |                                      |     |      |            |
| 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |                                  |   |   |                                   |                              |  |                                      |     |      |            |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>Nov 16</u> , 19 <u>79</u> , to <u>Dec 16</u> , 19 <u>79</u> , that (I) (we) lost saw the deceased alive on <u>Dec 15</u> , 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |                                  |   |   |                                   |                              |  |                                      |     |      |            |
| 22b. SIGNATURE <u>Anita Fu</u> DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>   |  |                                  |   |   |                                   |                              |  |                                      |     |      |            |
| 22c. DATE SIGNED <u>12/16/79</u>   |  |                                  |   |   |                                   |                              |  |                                      |     |      |            |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>ANITA FU</u>  |  |                                  |   |   |                                   |                              |  |                                      |     |      |            |
| 22e. ADDRESS <u>SINAI HOSPITAL</u>   |  |                                  |   |   |                                   |                              |  |                                      |     |      |            |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>  |  |                                  |   |   |                                   |                              |  |                                      |     |      |            |
| 23b. DATE <u>DEC. 18, 1979</u>   |  |                                  |   |   |                                   |                              |  |                                      |     |      |            |
| 23c. NAME OF CEMETERY OR CREMATORY <u>BALTIMORE HEBREW</u>   |  |                                  |   |   |                                   |                              |  |                                      |     |      |            |
| 23d. LOCATION CITY OR TOWN COUNTY STATE <u>REISTERSTOWN BALTO. MD</u>  |  |                                  |   |   |                                   |                              |  |                                      |     |      |            |
| 24. FUNERAL DIRECTOR NAME <u>SOL LEVINSON &amp; BROS., INC.</u>  |  |                                  |   |   |                                   |                              |  |                                      |     |      |            |
| 6010 REISTERSTOWN RD., BALTO., MD 21215  |  |                                  |   |   |                                   |                              |  |                                      |     |      |            |
| 25a. DATE REC'D. BY REGISTRAR <u>DEC 20 1979</u>   |  |                                  |   |   |                                   |                              |  |                                      |     |      |            |
| 25b. REGISTRAR'S SIGNATURE <u>Helen McLeod</u>   |  |                                  |   |   |                                   |                              |  |                                      |     |      |            |

OFFICE OF THE  
DIRECTOR OF THE  
BUREAU OF LAND MANAGEMENT



Handwritten signature and date: 3/10

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| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  |  |  |   |  |  |  |
|--|--|---|--|--|--|---|--|--|--|
| 1. FOR STATE REGISTRAR   |  | REG. NO. 79 30616   |  |  |  |   |  |  |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br>WILLIAM ROY SHIFLETT   |  |   |  | 2a. DATE OF DEATH MONTH DAY YEAR<br>DECEMBER 14, 1979  |  |   |  | 2b. HOUR<br>4:50 <sup>AM</sup>   |  |
| 3 SEX<br>Male  |  | 4 RACE<br>White   |  | 5 DATE OF BIRTH MONTH DAY YEAR<br>March 2 1916   |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br>63 YRS  |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Virginia  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |  | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.                                       |  |  |  |
| 10 CITY OR TOWN OF DEATH<br>Baltimore  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Church Hospital Corporation |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Steel Worker                   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Beth Steel  |  |
| 13a. STATE<br>Md   |  | 13b. COUNTY<br>Baltimore  |  | 13c. CITY OR TOWN<br>Dundalk   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS<br>7480 German Hill Rd. 21222  |  |
| 14 FATHER'S NAME FIRST MIDDLE LAST<br>Rollins Shiflett   |  |   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Sarah J. Shiflett  |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>Yes   |  | 16b. SOCIAL SECURITY NO.<br>WW II   |  | 17 INFORMANT<br>Mrs. Irene M. Shiflett   |  | ADDRESS Hill Rd. 21222<br>7480 German   |  |  |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) RESPIRATORY FAILURE<br>1629<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) CANCER OF LUNG<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)   |  |   |  |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |   |  |  |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |   |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |   |  |  |  |
| 22. I certify that (1) this hospital attended the deceased from 12-7-1979 to 12-14-1979, that (1) we lost<br>saw the deceased alive on 12-14-1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (1) (we) (did) (did not) view the body after death. |  |   |  |  |  |   |  |  |  |
| 22b. SIGNATURE<br>R. Surendra Sheno  |  |   |  | DEGREE   |  | 22c. DATE SIGNED<br>12-14-79  |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>K. SURENDRA SHENOY, M.D.  |  |   |  | 22e. ADDRESS CHURCH HOSPITAL CORPORATION<br>100 N. BROADWAY, BALTIMORE, MD 21231   |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial  |  | 23b. DATE<br>12/17/79   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Holly Hill Mem.  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br>White Marsh Balt. Md                                 |  |  |  |
| 24 FUNERAL DIRECTOR<br>Dudd-Ruck Inc. 7922 Wise Ave. Dundalk Md 21222  |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br>DEC 18 1979   |  | 25b. REGISTRAR'S SIGNATURE<br>Duffy McCready  |  |  |  |

BP





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

7 9 3 0 6 1 7  
REG. NO.

1 - FOR  
STATE  
REGISTRAR

|  |   |   |   |   |                                   |
|--|---|---|---|---|-----------------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Baby Boy Shird</b>            |   |   | 2a. DATE OF DEATH MONTH DAY YEAR <b>12/24 12 24 79</b>                  |   | 2b. HOUR <b>9:05 PM</b>           |
| 3 SEX <b>M</b>   | 4 RACE <b>B</b>   | 5. DATE OF BIRTH MONTH DAY YEAR <b>12 24 79</b>   |   | 6. AGE (IN YEARS LAST BIRTHDAY) <b>2</b> YRS. <b>13</b> MONTHS <b>2</b> DAYS <b>13</b> HOURS <b>13</b> MIN. |                                   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>            | 7b. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9 BALTIMORE CITY OR COUNTY OF DEATH <b>MD.</b>  |                                   |
| 10 CITY OR TOWN OF DEATH <b>Baltimore</b>                            | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Univ. of Maryland Hosp</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)        |   | 12b. KIND OF BUSINESS OR INDUSTRY |
| 13a. STATE <b>Maryland</b>   |   |   | 13b. COUNTY <b>Baltimore</b>  | 13c. CITY OR TOWN <b>Baltimore</b>  |                                   |
| 14. FATHER'S NAME FIRST MIDDLE LAST <b>L.V. Bell</b>                 |   |   | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Yvonne Cecelia Turner</b> |   |                                   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) |   | 16b. SOCIAL SECURITY NO.  |   | 17. INFORMANT ADDRESS   |                                   |

|   |  |   |
|---|--|---|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br><b>7798</b> IMMEDIATE CAUSE (a) <b>Cardiorespiratory Arrest</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Extreme Prematurity</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |
|---|--|---|

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

|  |  |  |  |  |   |
|--|--|--|--|--|---|
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. <b>19</b>      |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)       |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>12-24 19 79</b> , to <b>12-24 19 79</b> , that (I) (we) lost<br>saw the deceased alive on <b>12-24 19 79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |   |
| 22b. SIGNATURE<br><b>R. Cummings MD.</b>   |  |  |  | 22c. DATE SIGNED   |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>R. Cummings MD.</b>  |  |  |  | 22e. ADDRESS<br><b>Univ. of Md. Hosp</b>   |   |

|   |                           |  |  |
|---|---------------------------|--|--|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY) <b>Removal</b> | 23b. DATE <b>12/27/79</b> | 23c. NAME OF CEMETERY OR CREMATORY               | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE |
| 24 FUNERAL DIRECTOR<br>NAME <b>Anatomy Board</b>            |                           | 25a. DATE REC'D. BY REGISTRAR <b>DEC 31 1979</b> |  |
| ADDRESS <b>Balto., Md.</b>                                  |                           | 25b. REGISTRAR'S SIGNATURE                       |  |





1512  
 BP  
 DHMH - 17  
 (VR A15 ME (5))  
 30M 7/73

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. GIVE PAGES 4 AND 5 TO THE CHIEF MEDICAL EXAMINER. GIVE PAGES 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100, 101, 102, 103, 104, 105, 106, 107, 108, 109, 110, 111, 112, 113, 114, 115, 116, 117, 118, 119, 120, 121, 122, 123, 124, 125, 126, 127, 128, 129, 130, 131, 132, 133, 134, 135, 136, 137, 138, 139, 140, 141, 142, 143, 144, 145, 146, 147, 148, 149, 150, 151, 152, 153, 154, 155, 156, 157, 158, 159, 160, 161, 162, 163, 164, 165, 166, 167, 168, 169, 170, 171, 172, 173, 174, 175, 176, 177, 178, 179, 180, 181, 182, 183, 184, 185, 186, 187, 188, 189, 190, 191, 192, 193, 194, 195, 196, 197, 198, 199, 200, 201, 202, 203, 204, 205, 206, 207, 208, 209, 210, 211, 212, 213, 214, 215, 216, 217, 218, 219, 220, 221, 222, 223, 224, 225, 226, 227, 228, 229, 230, 231, 232, 233, 234, 235, 236, 237, 238, 239, 240, 241, 242, 243, 244, 245, 246, 247, 248, 249, 250, 251, 252, 253, 254, 255, 256, 257, 258, 259, 260, 261, 262, 263, 264, 265, 266, 267, 268, 269, 270, 271, 272, 273, 274, 275, 276, 277, 278, 279, 280, 281, 282, 283, 284, 285, 286, 287, 288, 289, 290, 291, 292, 293, 294, 295, 296, 297, 298, 299, 300, 301, 302, 303, 304, 305, 306, 307, 308, 309, 310, 311, 312, 313, 314, 315, 316, 317, 318, 319, 320, 321, 322, 323, 324, 325, 326, 327, 328, 329, 330, 331, 332, 333, 334, 335, 336, 337, 338, 339, 340, 341, 342, 343, 344, 345, 346, 347, 348, 349, 350, 351, 352, 353, 354, 355, 356, 357, 358, 359, 360, 361, 362, 363, 364, 365, 366, 367, 368, 369, 370, 371, 372, 373, 374, 375, 376, 377, 378, 379, 380, 381, 382, 383, 384, 385, 386, 387, 388, 389, 390, 391, 392, 393, 394, 395, 396, 397, 398, 399, 400, 401, 402, 403, 404, 405, 406, 407, 408, 409, 410, 411, 412, 413, 414, 415, 416, 417, 418, 419, 420, 421, 422, 423, 424, 425, 426, 427, 428, 429, 430, 431, 432, 433, 434, 435, 436, 437, 438, 439, 440, 441, 442, 443, 444, 445, 446, 447, 448, 449, 450, 451, 452, 453, 454, 455, 456, 457, 458, 459, 460, 461, 462, 463, 464, 465, 466, 467, 468, 469, 470, 471, 472, 473, 474, 475, 476, 477, 478, 479, 480, 481, 482, 483, 484, 485, 486, 487, 488, 489, 490, 491, 492, 493, 494, 495, 496, 497, 498, 499, 500, 501, 502, 503, 504, 505, 506, 507, 508, 509, 510, 511, 512, 513, 514, 515, 516, 517, 518, 519, 520, 521, 522, 523, 524, 525, 526, 527, 528, 529, 530, 531, 532, 533, 534, 535, 536, 537, 538, 539, 540, 541, 542, 543, 544, 545, 546, 547, 548, 549, 550, 551, 552, 553, 554, 555, 556, 557, 558, 559, 560, 561, 562, 563, 564, 565, 566, 567, 568, 569, 570, 571, 572, 573, 574, 575, 576, 577, 578, 579, 580, 581, 582, 583, 584, 585, 586, 587, 588, 589, 590, 591, 592, 593, 594, 595, 596, 597, 598, 599, 600, 601, 602, 603, 604, 605, 606, 607, 608, 609, 610, 611, 612, 613, 614, 615, 616, 617, 618, 619, 620, 621, 622, 623, 624, 625, 626, 627, 628, 629, 630, 631, 632, 633, 634, 635, 636, 637, 638, 639, 640, 641, 642, 643, 644, 645, 646, 647, 648, 649, 650, 651, 652, 653, 654, 655, 656, 657, 658, 659, 660, 661, 662, 663, 664, 665, 666, 667, 668, 669, 670, 671, 672, 673, 674, 675, 676, 677, 678, 679, 680, 681, 682, 683, 684, 685, 686, 687, 688, 689, 690, 691, 692, 693, 694, 695, 696, 697, 698, 699, 700, 701, 702, 703, 704, 705, 706, 707, 708, 709, 710, 711, 712, 713, 714, 715, 716, 717, 718, 719, 720, 721, 722, 723, 724, 725, 726, 727, 728, 729, 730, 731, 732, 733, 734, 735, 736, 737, 738, 739, 740, 741, 742, 743, 744, 745, 746, 747, 748, 749, 750, 751, 752, 753, 754, 755, 756, 757, 758, 759, 760, 761, 762, 763, 764, 765, 766, 767, 768, 769, 770, 771, 772, 773, 774, 775, 776, 777, 778, 779, 780, 781, 782, 783, 784, 785, 786, 787, 788, 789, 790, 791, 792, 793, 794, 795, 796, 797, 798, 799, 800, 801, 802, 803, 804, 805, 806, 807, 808, 809, 810, 811, 812, 813, 814, 815, 816, 817, 818, 819, 820, 821, 822, 823, 824, 825, 826, 827, 828, 829, 830, 831, 832, 833, 834, 835, 836, 837, 838, 839, 840, 841, 842, 843, 844, 845, 846, 847, 848, 849, 850, 851, 852, 853, 854, 855, 856, 857, 858, 859, 860, 861, 862, 863, 864, 865, 866, 867, 868, 869, 870, 871, 872, 873, 874, 875, 876, 877, 878, 879, 880, 881, 882, 883, 884, 885, 886, 887, 888, 889, 890, 891, 892, 893, 894, 895, 896, 897, 898, 899, 900, 901, 902, 903, 904, 905, 906, 907, 908, 909, 910, 911, 912, 913, 914, 915, 916, 917, 918, 919, 920, 921, 922, 923, 924, 925, 926, 927, 928, 929, 930, 931, 932, 933, 934, 935, 936, 937, 938, 939, 940, 941, 942, 943, 944, 945, 946, 947, 948, 949, 950, 951, 952, 953, 954, 955, 956, 957, 958, 959, 960, 961, 962, 963, 964, 965, 966, 967, 968, 969, 970, 971, 972, 973, 974, 975, 976, 977, 978, 979, 980, 981, 982, 983, 984, 985, 986, 987, 988, 989, 990, 991, 992, 993, 994, 995, 996, 997, 998, 999, 1000.

## MEDICAL CERTIFICATION

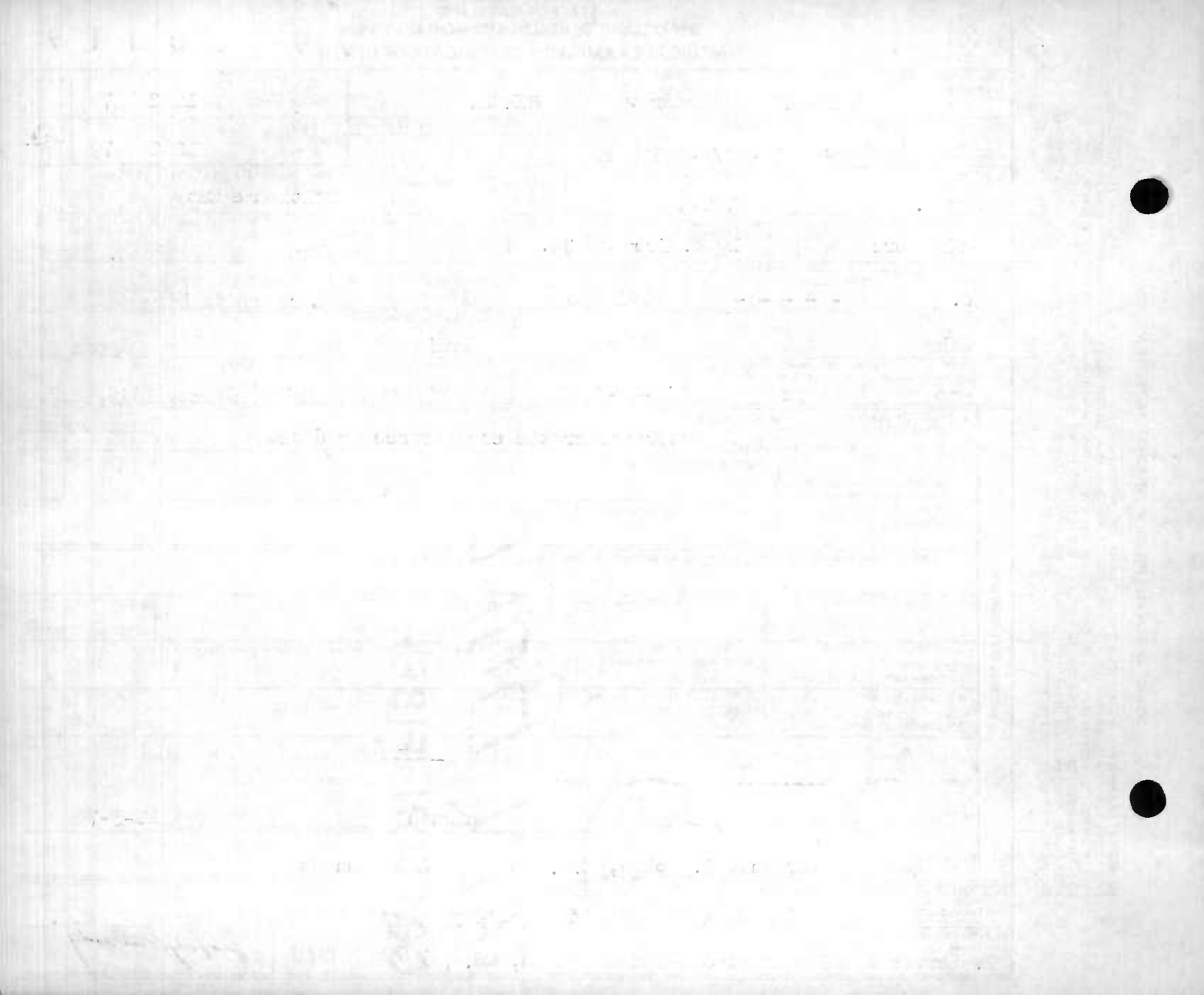
| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH   |  |   |  |  |  |   |  |  |  | REG. NO. 30618   |  |
|---|--|---|--|--|--|---|--|--|--|--|--|
| 1. FOR STATE REGISTRAR  |  | 1. DECEASED NAME<br>(TYPE OR PRINT) <b>LUCRETIA</b> |  |  |  |   |  | 2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> ESTIMATED <input type="checkbox"/> <b>12 17 19 79</b>  |  | 2b. HOUR <b>10:11 a m</b>  |  |
| 3. SEX <b>female</b>  |  | 4. RACE <b>negro</b>                                |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR <b>4 1 1940</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY) <b>39 YRS.</b>                                |  | 7. IF UNDER 1 YR. MONTHS DAYS HOURS MIN.   |  | 7c. DATE PRONOUNCED DEAD <b>12 17 19 79</b>                                      |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>South Carolina</b>   |  |   |  | 7b. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>   |  |   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.                   |  |
| 10. CITY OR TOWN OF DEATH <b>Baltimore</b>  |  |   |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>4701 Greenspring Ave.</b> |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| 13a. STATE <b>Maryland</b>  |  |   |  | 13b. COUNTY  |  | 13c. CITY OR TOWN <b>Baltimore</b>  |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 13e. STREET ADDRESS <b>2602 Springhill Avenue</b>                                |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST <b>Joe Black</b>   |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST <b>Susie Mae Gillard</b>   |  |   |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)  |  |   |  | 16b. SOCIAL SECURITY NO. <b>248-46-4848</b>  |  | 17. INFORMANT ADDRESS <b>Israel Black 19 North Bernice Avenue</b>             |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY: <b>Polycystic kidney disease</b><br><b>7531</b><br>IMMEDIATE CAUSE (a) <b>Polycystic kidney disease</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b)<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)   |  |   |  |  |  |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                     |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).   |  |   |  |  |  |   |  |  |  |  |  |
| 19a. DATE OF OPERATION  |  |   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |  |   |  |  |  | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |  |   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) |  |  |  |  |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                             |  |  |  |  |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: <b>Natural causes</b> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |  |   |  |  |  |   |  |  |  |  |  |
| ACTUAL SIGNATURE <b>[Signature]</b>   |  |   |  | TITLE (SPECIFY) <b>Assistant</b>   |  |   |  | DATE SIGNED <b>12-17-79</b>  |  |  |  |
| EXAMINER'S NAME (TYPE OR PRINT) <b>Ann M. Dixon, M.D.</b>   |  |   |  | ADDRESS <b>111 Penn Street</b>   |  |   |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>   |  |   |  | 23b. DATE <b>12/ 24/79</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY <b>King Memorial Park</b>                  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE <b>Baltimore Co., Maryland</b>  |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS <b>Wm. C. March F/H 1101 East North Avenue</b>   |  |   |  |  |  | 25a. DATE REC'D. BY REGISTRAR <b>DEC 20 1979</b>                              |  | 25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>  |  |  |  |



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR OUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITH VITAL RECORDS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

## MEDICAL CERTIFICATION

| 1. FOR STATE REGISTRAR   |  |         |  |                  |  |                   |  |                   |  | DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH |  |                          |  |  |                                      |  |           |  |  | REG. NO. 30619  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |
|--|--|---------|--|------------------|--|-------------------|--|-------------------|--|--|--|--------------------------|--|--|--------------------------------------|--|-----------|--|--|---|--|--|--|--|--|--|--|--|--|---|--|--|--|--|--|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  |         |  |                  | FIRST MIDDLE LAST  |                   |  |                   |  | 2a. DATE OF DEATH  |  |                          |  |  | 2b. HOUR                             |  |           |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |
| WILLIAM Woodrow SIKORA   |  |         |  |                  |  |                   |  |                   |  | 2a. DATE OF DEATH<br>KNOWN OF DEATH  |  |                          |  |  | 2b. HOUR<br>12 2 1979                |  |           |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |
| 3. SEX   |  | 4. RACE |  | 5. DATE OF BIRTH |  | 6. AGE (IN YEARS) |  | 7. IF UNDER 1 YR. |  | 8. IF UNDER 24 HRS.  |  | 2c. DATE PRONOUNCED DEAD |  |  |                                      |  | 2d. HOUR  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |
| male   |  | white   |  | 7 - 24 - 1917    |  | 62 YRS.           |  |                   |  |  |  | 12 2 1979                |  |  |                                      |  | 8:35 P.M. |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  |         |  |                  | 7b. CITIZEN OF WHAT COUNTRY?                             |                   |  |                   |  | 8. MARRIED   |  |                          |  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH |  |           |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |
| Penna.   |  |         |  |                  | U.S.A.   |                   |  |                   |  | WIDOWED  |  |                          |  |  | Baltimore City                       |  |           |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH  |  |         |  |                  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION |                   |  |                   |  | 12a. USUAL OCCUPATION (TYPE OF WORK)   |  |                          |  |  | 12b. KIND OF BUSINESS OR INDUSTRY    |  |           |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |
| Baltimore  |  |         |  |                  | 19 W. Preston St.  |                   |  |                   |  | Welder   |  |                          |  |  | Beth. Steel                          |  |           |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |
| 13a. STATE   |  |         |  |                  |  |                   |  |                   |  | 13b. CITY OR TOWN  |  |                          |  |  |                                      |  |           |  |  | 13c. INSIDE CITY LIMITS?  |  |  |  |  |  |  |  |  |  | 13d. STREET ADDRESS                     |  |  |  |  |  |  |  |  |  |
| Md.  |  |         |  |                  |  |                   |  |                   |  | Baltimore  |  |                          |  |  |                                      |  |           |  |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  |  |  |  |  |  |  |  | 26 E. Henreita Street                   |  |  |  |  |  |  |  |  |  |
| 14. FATHER'S NAME  |  |         |  |                  |  |                   |  |                   |  | 15. MOTHER'S MAIDEN NAME   |  |                          |  |  |                                      |  |           |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |
| John   |  |         |  |                  |  |                   |  |                   |  | Lydia  |  |                          |  |  |                                      |  |           |  |  | Lyons   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?   |  |         |  |                  |  |                   |  |                   |  | 16b. SOCIAL SECURITY NO.   |  |                          |  |  |                                      |  |           |  |  | 17. INFORMANT   |  |  |  |  |  |  |  |  |  | ADDRESS                                 |  |  |  |  |  |  |  |  |  |
| No   |  |         |  |                  |  |                   |  |                   |  | None   |  |                          |  |  |                                      |  |           |  |  | 188-18-3581   |  |  |  |  |  |  |  |  |  | Cecelia Sikora (wife) Jersey City, N.J. |  |  |  |  |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |  |         |  |                  |  |                   |  |                   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                       |  |                          |  |  |                                      |  |           |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |
| PART I DEATH WAS CAUSED BY:  |  |         |  |                  |  |                   |  |                   |  | IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease                        |  |                          |  |  |                                      |  |           |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |
| 4292   |  |         |  |                  |  |                   |  |                   |  | DUE TO, OR AS A CONSEQUENCE OF   |  |                          |  |  |                                      |  |           |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |
| Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.  |  |         |  |                  |  |                   |  |                   |  | (b)  |  |                          |  |  |                                      |  |           |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |
|  |  |         |  |                  |  |                   |  |                   |  | DUE TO, OR AS A CONSEQUENCE OF   |  |                          |  |  |                                      |  |           |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |
|  |  |         |  |                  |  |                   |  |                   |  | (c)  |  |                          |  |  |                                      |  |           |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).  |  |         |  |                  |  |                   |  |                   |  |  |  |                          |  |  |                                      |  |           |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  |         |  |                  |  |                   |  |                   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                                  |  |                          |  |  |                                      |  |           |  |  | 20. AUTOPSY?  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |
|  |  |         |  |                  |  |                   |  |                   |  |  |  |                          |  |  |                                      |  |           |  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |
| 21a. EXTERNAL CAUSE WAS  |  |         |  |                  |  |                   |  |                   |  | 21b. TIME OF INJURY  |  |                          |  |  |                                      |  |           |  |  | 21c. HOW INJURY OCCURRED  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |
| UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |  |         |  |                  |  |                   |  |                   |  | HOUR A.M. MONTH DAY YEAR   |  |                          |  |  |                                      |  |           |  |  | ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2                  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |
|  |  |         |  |                  |  |                   |  |                   |  | P.M. 19  |  |                          |  |  |                                      |  |           |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |
| 21d. INJURY OCCURRED   |  |         |  |                  |  |                   |  |                   |  | 21e. PLACE OF INJURY   |  |                          |  |  |                                      |  |           |  |  | 21f. LOCATION   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |
| WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |         |  |                  |  |                   |  |                   |  | (AT HOME, STREET, FACTORY, FARM, ETC.)   |  |                          |  |  |                                      |  |           |  |  | STREET CITY OR TOWN COUNTY STATE                                    |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |  |         |  |                  |  |                   |  |                   |  |  |  |                          |  |  |                                      |  |           |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |
| ACTUAL SIGNATURE   |  |         |  |                  |  |                   |  |                   |  | TITLE (SPECIFY)  |  |                          |  |  |                                      |  |           |  |  | DATE SIGNED   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |
| Virginia L. Dolan  |  |         |  |                  |  |                   |  |                   |  | Assistant  |  |                          |  |  |                                      |  |           |  |  | 12-3-79   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |
| EXAMINER'S NAME (TYPE OR PRINT)  |  |         |  |                  |  |                   |  |                   |  | ADDRESS  |  |                          |  |  |                                      |  |           |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |
| Virginia L. Dolan, M.D.  |  |         |  |                  |  |                   |  |                   |  | 111 Penn St.   |  |                          |  |  |                                      |  |           |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |  |         |  |                  |  |                   |  |                   |  | 23b. DATE  |  |                          |  |  |                                      |  |           |  |  | 23c. NAME OF CEMETERY OR CREMATORY                                  |  |  |  |  |  |  |  |  |  | 23d. LOCATION                           |  |  |  |  |  |  |  |  |  |
| Burial   |  |         |  |                  |  |                   |  |                   |  | 12/14/1979   |  |                          |  |  |                                      |  |           |  |  | Hillside Cemetery   |  |  |  |  |  |  |  |  |  | Rutherford Bergen N.J.                  |  |  |  |  |  |  |  |  |  |
| 24. FUNERAL DIRECTOR   |  |         |  |                  |  |                   |  |                   |  | 25a. DATE REC'D. BY REGISTRAR  |  |                          |  |  |                                      |  |           |  |  | 25b. REGISTRAR'S SIGNATURE  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |
| NAME   |  |         |  |                  |  |                   |  |                   |  | ADDRESS  |  |                          |  |  |                                      |  |           |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |
| E. Barnes Fleming Funeral Service Benson, Md.  |  |         |  |                  |  |                   |  |                   |  | DEC 13 1979  |  |                          |  |  |                                      |  |           |  |  | [Signature]   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 3 and 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |                 |  |  | 7 9 3 0 6 2 0<br>REG. NO.   |  |  |  |                                  |
|---|-----------------|--|--|---|--|--|--|----------------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>James Mather SILL  |                 |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>DECEMBER 20, 1979  |  |  |  | 2b. HOUR<br>10 <sup>30</sup> A M |
| 3 SEX<br>Male   | 4 RACE<br>White | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>Dec. 28, 1897  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>81 YRS.  |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN  |  |                                  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland   |                 | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.   |  |                                  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore  |                 | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Long Green Nursing Home |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Controller  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>S&N Katz  |  |                                  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>Maryland  |                 | 13b. COUNTY<br>Balto   |  | 13c. CITY OR TOWN<br>Baltimore  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |  |                                  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Howard Sill   |                 | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Mary Frances Duvall   |  |   |  |  |  |                                  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>Yes   |                 | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>WW I 212 03 2859  |  | 17. INFORMANT<br>ADDRESS<br>Mrs. Frances Sill Same  |  |  |  |                                  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY.<br>IMMEDIATE CAUSE (a) 4292 DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF<br>(c) <i>cardio-vascular disease</i><br><i>terminal congestive failure</i><br><i>due to gradual</i><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |                 |  |  |   |  |  |  |                                  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |                 |  |  |   |  |  |  |                                  |
| 19a. DATE OF OPERATION  |                 | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |                                  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |                 | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |                                  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |                 | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |                                  |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>Dec 19, 1979</i> to <i>12-20, 1979</i> , that (I) (we) lost saw the deceased alive on <i>Dec 19, 1979</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |                 |  |  |   |  |  |  |                                  |
| 22b. SIGNATURE<br><i>W H Woody</i>  |                 |  |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>        |  | 22c. DATE SIGNED<br>12-21-79   |  |                                  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Dr. W. H. Woody, M.D.  |                 |  |  | 22e. ADDRESS<br>102 Church Warden's Road Balto., Md.  |  |  |  |                                  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial   |                 | 23b. DATE<br>12/22/79  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Holy Trinity  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Bowie, Maryland  |  |                                  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Henry W. Jenkins & Sons Co.<br>4905 York Road Balto., Md. 21212   |                 |  |  | 25a. DATE REC'D. BY REGISTRAR<br>DEC 21 1979  |  | 25b. REGISTRAR'S SIGNATURE<br><i>Robert A. Woody</i>   |  |                                  |

1/20/50

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

7 9 3 0 6 2 1

FOR  
1 - STATE  
REGISTRAR

REG. NO.

|   |   |  |  |  |   |
|---|---|--|--|--|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Theresa C SIMMONS  |   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>12-23-79                                |  | 2b. HOUR<br>5:50 PM   |
| 3 SEX<br>Female   | 4 RACE<br>Black   | 5 DATE OF BIRTH<br>MONTH DAY YEAR<br>11 10 18  | 6 AGE (IN YEARS LAST BIRTHDAY)<br>61 YRS.                                      |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN  |
| 7a BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br>VIRGINIA   | 7b CITIZEN OF WHAT COUNTRY?<br>United States  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9 BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore MD.                           |  |   |
| 10. CITY OR TOWN OF DEATH<br>Maryland   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>730 Ashburton Street | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>RETIRED  | 12b. KIND OF BUSINESS OR INDUSTRY<br>FOOD SERVICE                              |  |   |
| 13a. STATE<br>2775 Baker Street   |   | 13b. CITY OR TOWN  | 13c. STREET ADDRESS<br>2775 Baker Street                                       |  |   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>JOSEPH CONNOR   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>LILLIAN ANN BURNETT   |  |  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>UNKNOWN   |   | 16b. SOCIAL SECURITY NO.<br>219 12 6481  | 17. INFORMANT<br>ADDRESS<br>730 Ashburton St. Balt. Md.                        |  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Hepatic failure<br>5712<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) Complications of liver.<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) Accidents.<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) |   |  |  |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH   |
| 19a. DATE OF OPERATION  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |  |   |
| 22a. I certify that (I) (this hospital) attended the deceased from 10-04-79, 19 to 12-23, 1979, that (we) last saw the deceased alive on 12-23, 1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I/we) (did) (did not) view the body after death.  |   |  |  |  |   |
| 22b. SIGNATURE<br>Sissay Awake  |   | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>       |  | 22c. DATE SIGNED<br>12-23-79   |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Sissay Awake   |   | 22e. ADDRESS<br>In the Hospital  |  |  |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>BURIAL  | 23b. DATE<br>12/27/79   | 23c. NAME OF CEMETERY OR CREMATORY<br>FAMILY ESTATE  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>HEATHSVILLE (NORTHUMBERLAND) VA.       |   |
| 24. FUNERAL DIRECTOR<br>NAME<br>LEWIS T. GWYNN  |   | ADDRESS<br>4517 PARK HEIGHTS AVENUE  |  | 25a. DATE REC'D. BY REGISTRAR<br>DEC 26 1979   | 25b. REGISTRAR'S SIGNATURE<br>Pittsburgh  |



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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 3 0 6 2 2

|  |                              |   |  |   |                                      |  |                                      |  |                     |                                      |   |          |
|--|------------------------------|---|--|---|--------------------------------------|--|--------------------------------------|--|---------------------|--------------------------------------|---|----------|
| 1. FOR STATE REGISTRAR   |                              | 1. DECEASED NAME<br>(TYPE OR PRINT)                           |  | FIRST   | MIDDLE                               | LAST   | 2a. DATE KNOWN OF DEATH              | 2b. DATE ESTIMATED   | MONTH               | DAY                                  | YEAR  | 7b. HOUR |
|  |                              | WALTER EMANUEL SIMMS  |  |   |                                      |  |                                      |  |                     |                                      |   |          |
| 3. SEX   | 4. RACE                      | 5. DATE OF BIRTH  | 6. AGE (IN YEARS)  | IF UNDER 1 YR.  | IF UNDER 24 HRS.                     | 7c. DATE PRONOUNCED DEAD   | 8. BALTIMORE CITY OR COUNTY OF DEATH |  |                     | 9. BALTIMORE CITY OR COUNTY OF DEATH |   |          |
| male   | black                        | 12-9-36   | 46 YRS.  |   |                                      | 12-26-79   | Baltimore City                       |  |                     | Baltimore City                       |   |          |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  | 7b. CITIZEN OF WHAT COUNTRY? |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH |  |                                      | 10. CITY OR TOWN OF DEATH  |                     |                                      | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |          |
| Baltimore City   | U. S. A.                     |   |  |   | Baltimore City                       |  |                                      | Baltimore  |                     | 2003 Hollins Street                  |   |          |
| 12a. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |                              | 12b. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) |  | 12c. KIND OF BUSINESS OR INDUSTRY   |                                      | 13a. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                      |  | 13b. STREET ADDRESS |                                      |   |          |
| Md.  |                              | Unemployed  |  |   |                                      | YES  |                                      |  | 2003 Hollins St.    |                                      |   |          |
| 14. FATHER'S NAME  |                              | 15. MOTHER'S MAIDEN NAME                                      |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)            |                                      | 16b. SOCIAL SECURITY NO.   |                                      | 17. INFORMANT  |                     | ADDRESS                              |   |          |
| John F. Brooks   |                              | Miltada Simms   |  | Yes   |                                      | 219-26-4681  |                                      | Mrs. Alma Simms  |                     | 2716 Spelling Rd.                    |   |          |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1 DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Fatty liver</u><br>5718 } DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the <u>underlying</u> cause last. }<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____  |                              |   |  |   |                                      |  |                                      |  |                     |                                      |   |          |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).  |                              |   |  |   |                                      |  |                                      |  |                     |                                      |   |          |
| 19a. DATE OF OPERATION   |                              | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?             |  |   |                                      |  |                                      | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                     |                                      |   |          |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |                              | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR                  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) |                                      |  |                                      |  |                     |                                      |   |          |
|  |                              | P.M. 19   |  |   |                                      |  |                                      |  |                     |                                      |   |          |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |                              | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                |                                      |  |                                      |  |                     |                                      |   |          |
|  |                              |   |  |   |                                      |  |                                      |  |                     |                                      |   |          |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |                              |   |  |   |                                      |  |                                      |  |                     |                                      |   |          |
| ACTUAL SIGNATURE   |                              | TITLE (SPECIFY)   |  | DATE SIGNED   |                                      |  |                                      |  |                     |                                      |   |          |
|  |                              | Assistant   |  | 12/27/79  |                                      |  |                                      |  |                     |                                      |   |          |
| EXAMINER'S NAME (TYPE OR PRINT)  |                              | ADDRESS   |  |   |                                      |  |                                      |  |                     |                                      |   |          |
| Margarita A. Korell, M.D.  |                              | 111 Penn Street   |  |   |                                      |  |                                      |  |                     |                                      |   |          |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |                              | 23b. DATE   |  | 23c. NAME OF CEMETERY OR CREMATORY  |                                      | 23d. LOCATION CITY OR TOWN   |                                      | COUNTY   |                     | STATE                                |   |          |
| Burial   |                              | 1/2/1980  |  | Arbustus Mem. Park  |                                      | Arbustus, Md.  |                                      |  |                     |                                      |   |          |
| 24. FUNERAL DIRECTOR NAME  |                              | ADDRESS   |  | 25a. DATE REC'D. BY REGISTRAR   |                                      | 25b. REGISTRAR'S SIGNATURE   |                                      |  |                     |                                      |   |          |
| Joseph C. Russ   |                              | 22226 North   |  | DEC 27 1979   |                                      | L. J. Kelly  |                                      |  |                     |                                      |   |          |



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

7 9 3 0 6 2 3

1. FOR  
STATE  
REGISTRAR1. DECEASED NAME  
(TYPE OR PRINT)FIRST MIDDLE LAST  
Sallie J. Simpson2a. DATE OF DEATH MONTH DAY YEAR  
12 28 792b. HOUR  
M

3. SEX

Female

4. RACE

Black

5. DATE OF BIRTH

MONTH DAY YEAR  
3 15 1920

6. AGE (IN YEARS LAST BIRTHDAY)

59 YRS

IF UNDER 1 YEAR

MONTHS DAYS

IF UNDER 24 HRS

HOURS MIN.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)

South Carolina

7b. CITIZEN OF WHAT COUNTRY?

U.S.A.

8. MARRIED ☒ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH

Balto. City MD

10. CITY OR TOWN OF DEATH

Baltimore

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)

2212 Penrose Ave

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)

12b. KIND OF BUSINESS OR INDUSTRY

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE

MD

13b. COUNTY

13c. CITY OR TOWN

Baltimore

13d. INSIDE CITY LIMITS?

YES ☒ NO ☐

13e. STREET ADDRESS

2212 Penrose Ave

14. FATHER'S NAME

FIRST MIDDLE LAST  
Unknown

15. MOTHER'S MAIDEN NAME

FIRST MIDDLE LAST  
Pansy Hicks

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)

No

16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)

213-26-2340

17. INFORMANT

ADDRESS  
John Simpson 2212 Penrose Ave

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART 1. DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a)

Cardiopulmonary arrest

1820

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

(b) uremia

DUE TO, OR AS A CONSEQUENCE OF

(c) stage IV B cancer of endometrium

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

MEDICAL CERTIFICATION

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY?

YES ☐ NO ☐

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?

YES ☐ NO ☐21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR  
P.M. 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21d. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION

STREET

CITY OR TOWN

COUNTY

STATE

22a. I certify that (I) (this hospital) attended the deceased from 1979, to Dec 1979, that (I) (we) lost saw the deceased alive on Dec 1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE

Marciana Washington

DEGREE

M.D.

ATTENDING PHYSICIAN ☒MEDICAL DIRECTOR ☐STAFF PHYSICIAN ☐

22c. DATE SIGNED

12/28/79

22d. PHYSICIAN'S NAME (TYPE OR PRINT)

Marciana Washington

22e. ADDRESS

22 S. Greene St. Balt., MD

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)

Burial

23b. DATE

1/4/80

23c. NAME OF CEMETERY OR CREMATORY

Baltimore Cem.

23d. LOCATION

Baltimore, Md.

COUNTY

STATE

24. FUNERAL DIRECTOR

NAME

Wm C March F/H

ADDRESS

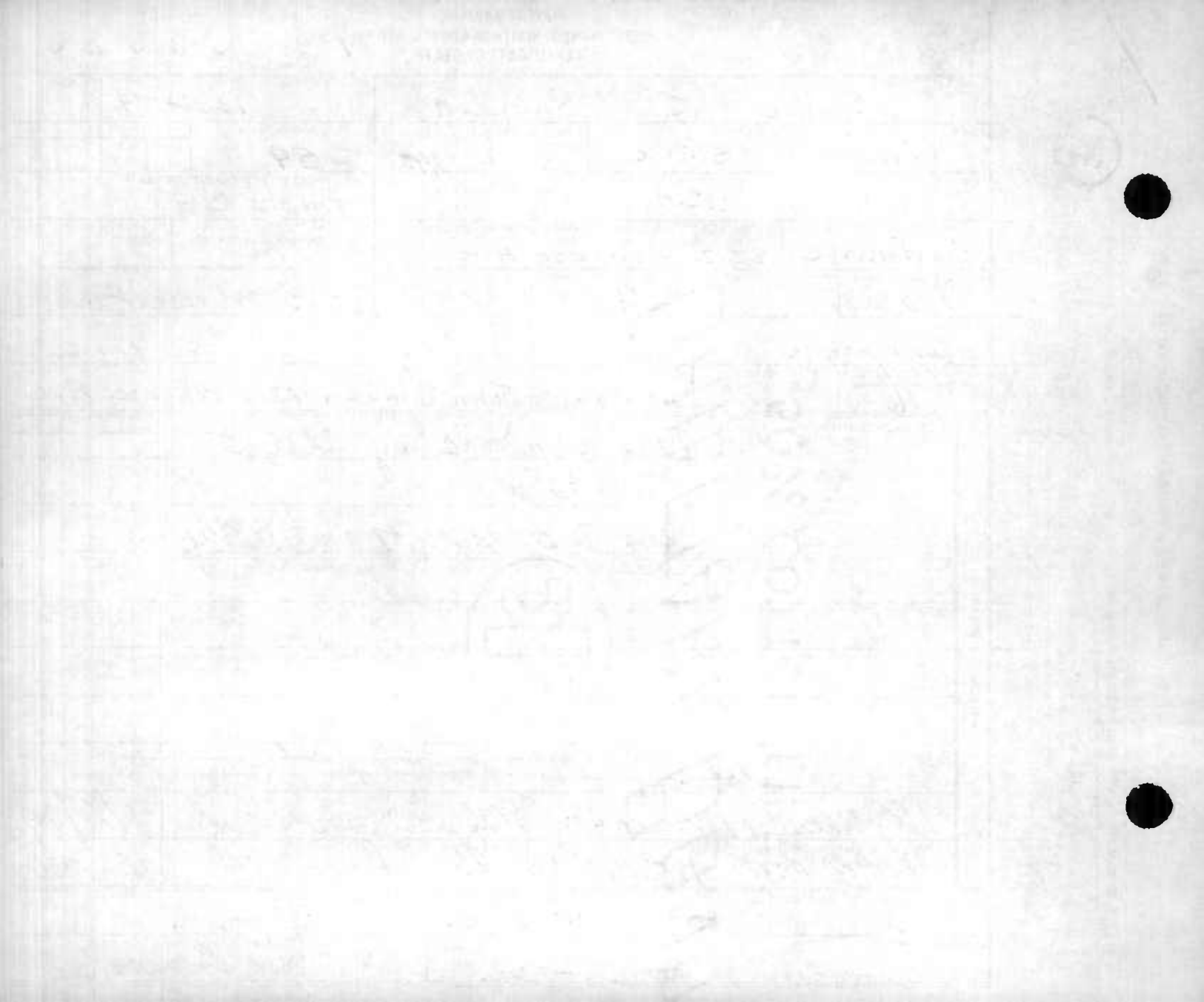
1101 E. North Ave.

25a. DATE REC'D. BY REGISTRAR

JAN 3 1980

25b. REGISTRAR'S SIGNATURE

Lutay McBrady



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  |   |  |   |  |   |  |
|---|--|---|--|---|--|---|--|---|--|
| 1. FOR<br>STATE<br>REGISTRAR  |  |   |  |   | REG. NO. 7 9 3 0 6 2 4   |   |  |   |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Robert Allison SINDALL, Jr.  |  |   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>12-23-79                |   |  | 2b. HOUR<br>8:30 PM   |  |
| 3 SEX<br>Male   |  | 4 RACE<br>White   |  | 5 DATE OF BIRTH<br>MONTH DAY YEAR<br>Dec. 9, 1911   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>68 YRS.  |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.                                      |  |   |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>3908 N. Charles Street |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Executive                   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Food Processing  |  |
| 13a. STATE<br>Maryland  |  | 13b. COUNTY   |  | 13c. CITY OR TOWN<br>Baltimore  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br>3908 N. Charles St. Equip.   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Robert Allison Sindall Sr.  |  |   |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Marie Bramble |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>Yes   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>WW II  |  | 17. INFORMANT<br>Mrs. Eunice Sindall  |  |   | ADDRESS<br>Same  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line form 1, 1b1, and 1c)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarction</u><br>410-<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost }<br>DUE TO, OR AS A CONSEQUENCE OF (b) <u>ASHD</u><br>DUE TO, OR AS A CONSEQUENCE OF (c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>5 years</u> |  |   |  |   |  |   |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><u>Chronic Obstructive Lung Disease</u>  |  |   |  |   |  |   |  |   |  |
| 19a. DATE OF OPERATION<br>—   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br>—   |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED<br>(ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)<br>—  |  |   |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)<br>—   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br>— — — — —  |  |   |  |   |  |
| 22a. I certify that (1) (this hospital) attended the deceased from 19 <u>74</u> to <u>Dec</u> 19 <u>79</u> , that (1) (we) lost saw the deceased alive on <u>12/21</u> 19 <u>79</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) did (did not) view the body after death.  |  |   |  |   |  |   |  |   |  |
| 22b. SIGNATURE<br><u>Robert I. Levy</u>   |  |   |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>        |  |   |  | 22c. DATE SIGNED<br><u>12/23/79</u>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><u>Robert I. Levy, MD.</u>   |  |   |  | 22e. ADDRESS<br><u>114 Medical Arts Bldg, Balto., Md.</u>   |  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><u>Burial</u>  |  | 23b. DATE<br><u>12/27/79</u>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Druid Ridge</u>  |  |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><u>Pikesville, Md.</u> |   |  |
| 24. FUNERAL DIRECTOR<br>NAME Henry W. Jenkins & Sons Co.<br>ADDRESS 4905 York Road Balto., Md. 21212  |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><u>DEC 27 1979</u>   |  | 25b. REGISTRAR'S SIGNATURE<br><u>Robert I. Levy</u>   |  |   |  |





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  | REG. NO. 79 30625  |  |  |  |
|---|--|--|--|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Annie m Singel</b>   |  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>12 23 79</b>   |  | 2b. HOUR<br><b>7:45 P.M.</b>   |  |
| 3 SEX<br><b>FEMALE</b>  |  | 4 RACE<br><b>White</b>   |  | 5 DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Dec. 24, 1889</b>  |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br><b>89</b>  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Czechoslovakia</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.   |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>ST. AGNES HOSPITAL</b> |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Homemaker</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE <b>Maryland</b> 13b. COUNTY <b>Howard</b> 13c. CITY OR TOWN <b>Ellicott City</b>   |  |  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 13e. STREET ADDRESS<br><b>9814 Michaels Way</b>  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Michael Lasko</b>  |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Mary Chuba</b>   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>None</b>  |  | 17. INFORMANT<br>ADDRESS<br><b>Anna M. Appler 9814 Michaels Way Ellicott Cty</b>   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <b>CARDIO RESPIRATORY ARREST</b><br><b>410 -</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>ACUTE EXTENSIVE MI WITH</b><br>Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause last<br>DUE TO, OR AS A CONSEQUENCE OF <b>SHOCK SECONDARY TO</b><br>(c) <b>TRIFASCICULAR BLOCK</b> |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)   |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |  |  |
| 21d. INJURY OCCURRED<br>WHERE <input type="checkbox"/> NOT WHERE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>Dec 23rd 1979</b> to <b>Dec 23rd 1979</b> , that (I) (we) last saw the deceased alive on <b>Dec 23rd 1979</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |  |  |  |  |  |  |
| 22b. SIGNATURE<br><b>D.P. HULL KUNDE TATTERDAKER</b>  |  |  |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>       |  | 22c. DATE SIGNED<br><b>12/23/79</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>D.P. HULL KUNDE TATTERDAKER</b>   |  |  |  | 22e. ADDRESS<br><b>900 CATON AVE. BALTIMORE, MD. 21229</b>   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br><b>Burial</b>  |  | 23b. DATE<br><b>Dec 28, 1979</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Corpus Christi</b>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Dunl0 Cambria Penna</b>   |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Hubbard FH Inc 4107 Wilkens Ave Balt Md.</b>   |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>DEC 24 1979</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>   |  |

1 2 3 4 5 6 7 8 9 10 11 12

12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50 51 52 53 54 55 56 57 58 59 60 61 62 63 64 65 66 67 68 69 70 71 72 73 74 75 76 77 78 79 80 81 82 83 84 85 86 87 88 89 90 91 92 93 94 95 96 97 98 99 100

BALTIMORE CITY

ST. AGNES HOSPITAL

BALTIMORE

1000 CATON AVE. BALTIMORE, MD. 21229



Item 106 g539 1/7/80 gj

FOR  
1 - STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH7 9 3 0 6 2 6  
REG. NO.

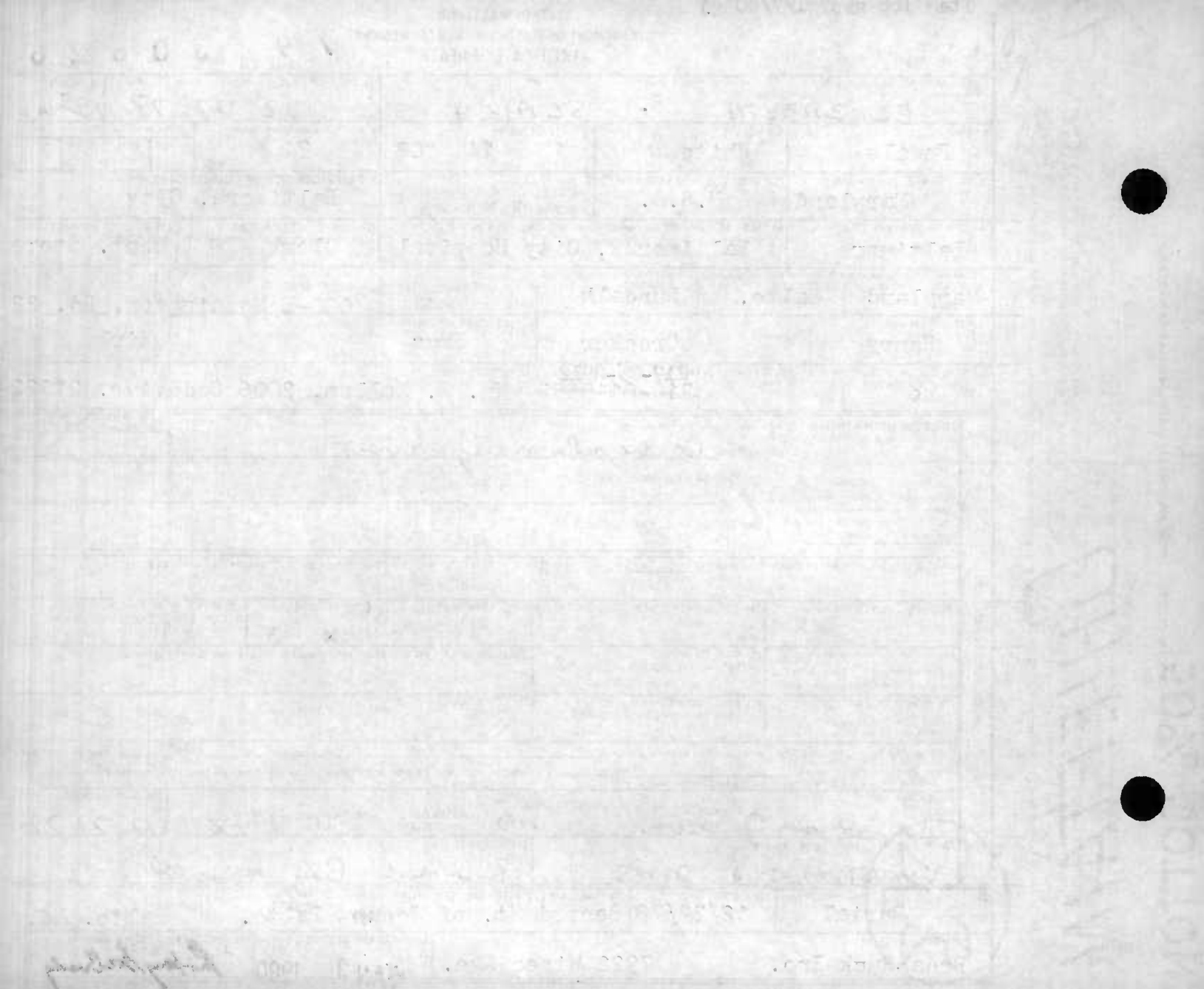
|  |  |   |  |   |   |  |  |  |  |  |  |
|--|--|---|--|---|---|--|--|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>ELIZABETH E. SLAICH   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>12-27-79                        |   |   | 2b. HOUR<br>153 4 M  |  |  |  |  |  |
| 3. SEX<br>Female   |  | 4. RACE<br>White  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>9 14 08   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>71  |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.   |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore, City MD.  |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN HUGH FACILITY, GIVE STREET ADDRESS)<br>Baltimore, City Hospital |  |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Clerk  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Dept. Store   |  |  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE Maryland 13b. COUNTY Balto. 13c. CITY OR TOWN Dundalk   |  |   |  |   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |  | 13e. STREET ADDRESS<br>7000-B Morningside Rd. 22 |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Henry Crocker  |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Emma Kirby   |   |  |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) no  |  |   |  | 16b. U.S. SECURITY NO.<br>216-01-5559   |   | 17. INFORMANT<br>ADDRESS<br>Wm. E. Mullen, 2006 Codd Ave. 21222  |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cardiovascular arrest</u><br>4275<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |  |   |  |   |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |   |  |   |   |  |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |   | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost<br>saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.                                    |  |   |  |   |   |  |  |  |  |  |  |
| 22b. SIGNATURE<br>Christopher J. Davis MD  |  |   |  |   |   | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br>12-27-79   |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>CHRISTOPHER J. DAVIS  |  |   |  |   |   | 22e. ADDRESS<br>Baltimore City Hospital  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial   |  |   | 23b. DATE<br>12/29/79  |   | 23c. NAME OF CEMETERY OR CREMATORY<br>Sacred Ht. of Jesus                                       |  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Balto. Balto. Md.  |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Duda-Ruck Inc.   |  |   |  |   |   | ADDRESS<br>7922 Wise Ave.  |  | 25a. DATE REC'D. BY REGISTRAR<br>JAN 3 1980  |  |  |  |
| 25b. REGISTRAR'S SIGNATURE<br>Kristy H. Brady  |  |   |  |   |   |  |  |  |  |  |  |

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.



BP

DHMH-16 50M 7/77  
(VR A 15 (4))

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

7930627

REG. NO.

|  |  |   |   |  |  |  |  |
|--|--|---|---|--|--|--|--|
| 1. FOR STATE REGISTRAR   |  | 2a. DATE OF DEATH   |   | MONTH DAY YEAR   |  | 2b. HOUR   |  |
| 1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br>ROSE SLATNICK   |  | 12-18-79  |   | 936 P.M.   |  |  |  |
| 3. SEX<br>FEMALE   | 4. RACE<br>CAUCASIAN   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>7 4 94  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>85 YRS.  | IF UNDER 1 YEAR<br>MONTHS DAYS   |  | IF UNDER 24 HRS.<br>HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>RUSSIA  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD.                                      |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>SINAL Hosp |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>HOUSEWIFE                      |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>AT HOME |  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  | APT. 1018 #21215  |   |  |  |  |  |
| 13a. STATE<br>MD.  | 13b. COUNTY  | 13c. CITY OR TOWN<br>Baltimore  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS<br>2500 W. BELVEDERE AVE   |  |  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>UNKNOWN   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>UNKNOWN   |   |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>NO  |  | 16b. SOCIAL SECURITY NO.<br>215-56-4298   |   | 17. INFORMANT<br>MR. SIDNEY SLATNICK<br>8402 BILLSON RD., RANDALLSTOWN, MD 21133     |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a)<br>410-<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) Myocardial Infarction<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) HBP DM. ASCVD |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>2 wk  |   |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)  |  |   |   |  |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)       |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 12/18, 1979, to 12/18, 1979, that (I) (we) last saw the deceased alive on 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |   |   |  |  |  |  |
| 22b. SIGNATURE<br>[Signature]  |  | DEGREE  |   | 22c. DATE SIGNED<br>12/18/79   |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Victor M. Salcedo   |  | 22e. ADDRESS<br>SINAL Hosp. Balt. Md.   |   |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>BURIAL  |  | 23b. DATE<br>DEC. 20, 1979  |   | 23c. NAME OF CEMETERY OR CREMATORY<br>BOBROISKER BEN. CIR.                           |  | 23d. LOCATION<br>ROSEDALE BALTO. MD.   |  |
| 24. FUNERAL DIRECTOR<br>NAME SOL LEVINSON & BROS., INC.  |  | ADDRESS<br>6010 REISTERSTOWN RD. BALTO., MD 21215   |   | 25a. DATE REC'D. BY REGISTRAR<br>DEC 27 1979   |  | 25b. REGISTRAR'S SIGNATURE<br>[Signature]  |  |



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP  
DHMH-17  
(VR 415 ME (5))  
15M 7/76

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 30628

FOR  
1- STATE  
REGISTRAR

|  |                              |  |  |   |   |   |
|--|------------------------------|--|--|---|---|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Frances A. Slaughter</b>   |                              |  | 2a. DATE KNOWN OF DEATH<br>ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR<br><b>12 19 1979</b> |   |   | 2b. HOUR<br>M<br><b>8:49A</b>                                     |
| 3. SEX<br><b>Female</b>  | 4. RACE<br><b>Black</b>      | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>10-21-41</b>  | 6. AGE (IN YEARS)<br>LAST BIRTHDAY<br><b>38</b> YRS.   | IF UNDER 1 YR.<br>MONTHS DAYS HOURS MIN.  | 7c. DATE PRONOUNCED DEAD<br>MONTH DAY YEAR<br><b>12 19 1979</b>                     | 7d. HOUR<br>M<br><b>8:49A</b>                                     |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Virginia</b>   |                              | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD. |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore City</b>   |                              | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Lutheran Hospital</b> |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>unk</b>   |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>---</b>                   |
| 13a. STATE<br><b>md.</b>   |                              | 13b. COUNTY<br><b>Balto.</b>   | 13c. CITY OR TOWN<br><b>Balto.</b>   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   | 13e. STREET ADDRESS<br><b>2740 Winchester St. 21216</b>                             |   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Richard R. Chandler</b>   |                              |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Pauline Montgomery</b>                                   |   |   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br><b>no</b>   |                              | 16b. SOCIAL SECURITY NO.<br><b>234-64-6961</b>   |  | 17. INFORMANT<br>ADDRESS<br><b>Claudette P. Cockett - 2740 Winchester St.</b>   |   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Arteriosclerotic cardiovascular disease</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH          |                              |  |  |   |   |   |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).  |                              |  |  |   |   |   |
| 19a. DATE OF OPERATION   |                              | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |  |   | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |                              | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |   |   |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |                              | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |   |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |                              |  |  |   |   |   |
| ACTUAL SIGNATURE<br><b>H.R. Suato</b>  |                              | M.D. <b>Assistant</b>  |  | DATE SIGNED <b>12/19/79</b>   |   |   |
| EXAMINER'S NAME<br>(TYPE OR PRINT)<br><b>Hormez R. Guard, M.D.</b>   |                              | ADDRESS <b>111 Penn St. Balto., MD.</b>  |  |   |   |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  | 23b. DATE<br><b>12/24/79</b> | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Arbutus Mem. Pk.</b>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Maryland</b>   |   |   |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Calvin B. Scruggs 1412 E. Preston</b>   |                              | 25a. DATE REC'D. BY REGISTRAR<br><b>DEC 21 1979</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>Barney McCurdy</b>   |   |   |

10-21-41

10-21-41

11-2-41

Virginia

Black

Barber

11-8

Richard R. Chandler

Richard R. Chandler

11-8

11-8

11-8

12/21/41

12/21/41

12/21/41

12/21/41

12/21/41

12/21/41

12/21/41

12/21/41

12/21/41

12/21/41

12/21/41



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

7 9 3 0 6 2 9  
REG. NO.

|   |  |   |   |  |   |
|---|--|---|---|--|---|
| 1. FOR STATE REGISTRAR  |  | 2a. DATE OF DEATH MONTH DAY YEAR  |   | 2b. HOUR   |   |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br><i>William F. Slaughter</i>   |  | 12-25-79  |   | 1 P. M.  |   |
| 3. SEX<br><i>Male</i>   | 4. RACE<br><i>White</i>  | 5. DATE OF BIRTH MONTH DAY YEAR<br><i>4-25-22</i>   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><i>57</i> YRS.                               | IF UNDER 1 YEAR MONTHS DAYS  | IF UNDER 24 HRS. HOURS MIN.                             |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><i>Balto. Md.</i>  | 7b. CITIZEN OF WHAT COUNTRY?<br><i>U.S.A.</i>  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><i>Baltimore City</i> MD.               |  |   |
| 10. CITY OR TOWN OF DEATH<br><i>Baltimore</i>   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><i>3807 Forrester Avenue</i> |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><i>Retired</i> | 12b. KIND OF BUSINESS OR INDUSTRY<br><i>Govt. Employee</i>                                   |   |
| 13a. STATE<br><i>Md.</i>  |  | 13b. COUNTY<br><i>Balto.</i>  | 13c. CITY OR TOWN<br><i>Balto.</i>  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS<br><i>3807 Forrester Ave. 21206</i> |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><i>Leo Slaughter</i>   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><i>Clara Heilman</i>  |   |  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br><i>Yes</i>   |  | 16b. SOCIAL SECURITY NO.<br><i>213-12-8360</i>  |   | 17. INFORMANT ADDRESS<br><i>Mrs. Ethel M. Slaughter 3807 Forrester Ave. 21206</i>            |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>CARDIAC ARREST</i><br><i>4275</i><br>DUE TO, OR AS A CONSEQUENCE OF (b) _____<br>DUE TO, OR AS A CONSEQUENCE OF (c) _____<br>CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST. |  |   |   |  |   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i>OLIVOPONTO CEREBELLAR DEGENERATION</i>   |  |   |   |  |   |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>                       |   |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>   |  |   |   |  |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <i>19</i>   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)               |   |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |   | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>9/2</i> 19 <i>75</i> , to <i>DEC</i> 19 <i>79</i> , that (I) (we) last saw the deceased alive on <i>MAY 3</i> 19 <i>79</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.     |  |   |   |  |   |
| 22b. SIGNATURE<br><i>Solomon D. Robbins M.D.</i>  |  | DEGREE<br><i>M.D.</i>   |   | 22c. DATE SIGNED<br><i>12/28/79</i>  |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><i>Solomon D. Robbins</i>  |  | 22e. ADDRESS<br><i>10211 S. DOLFIELD OWINGS MILLS MD 21117</i>  |   |  |   |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><i>Burial</i>  | 23b. DATE<br><i>12-30-79</i>   | 23c. NAME OF CEMETERY OR CREMATORY<br><i>Dulaney Valley Cem.</i>  | 23d. LOCATION CITY OR TOWN<br><i>Cockeysville, Md.</i>                          | 23e. STATE<br><i>MD</i>  |   |
| 24. FUNERAL DIRECTOR<br><i>John C. Miller Inc., 6415 Belair Rd. - 21206</i>   |  | 25. DATE REC'D BY REGISTRAR 75b. REGISTRAR'S SIGNATURE<br><i>JAN 2 1980</i>   |   |  |   |

POST OFFICE

WATER



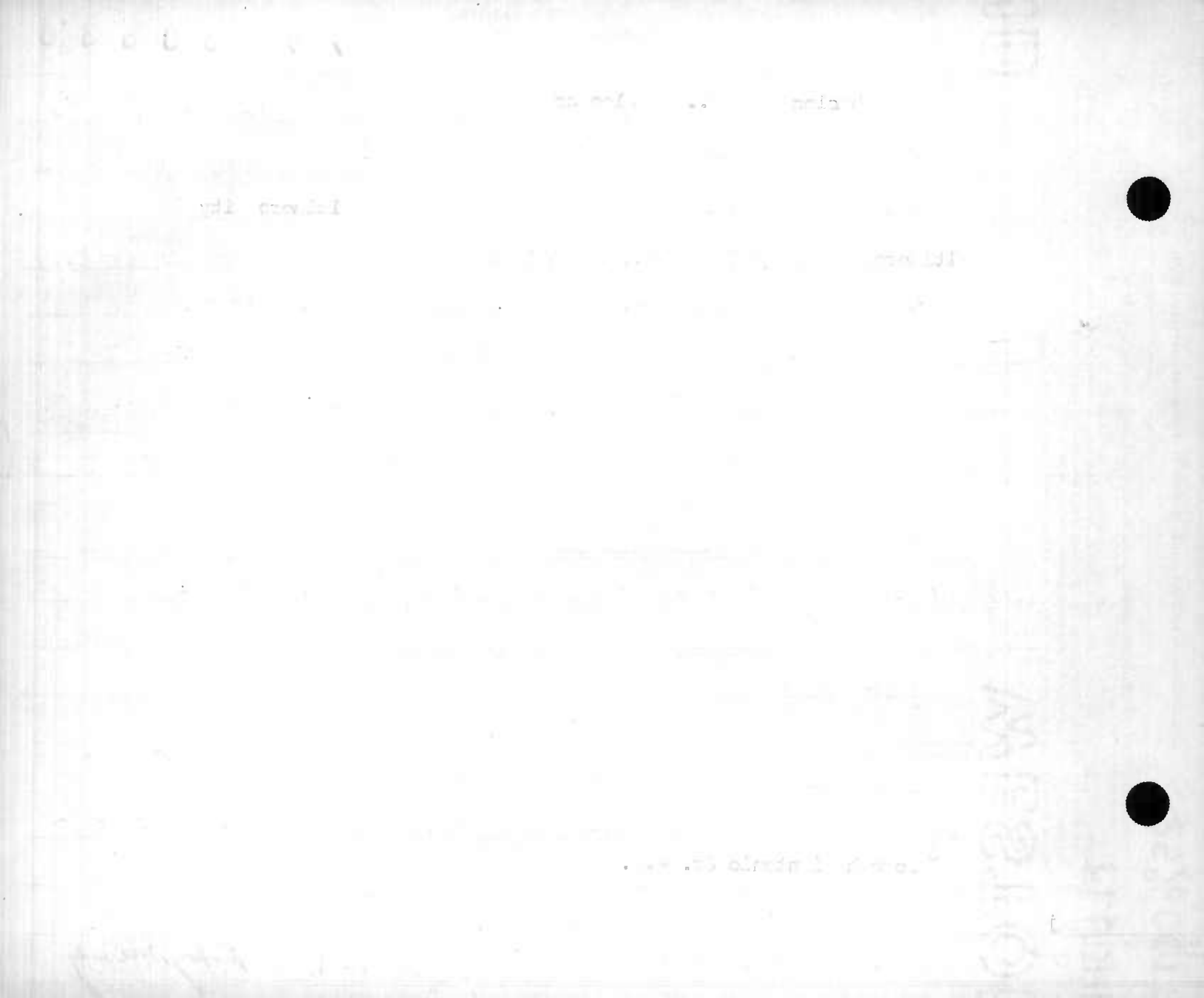


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |                              |  |   |                                    |  |  |  |                                   | 79 30630                                     |                   |  |
|---|--|------------------------------|--|---|------------------------------------|--|--|--|-----------------------------------|--|-------------------|--|
| 1. FOR STATE REGISTRAR  |  |                              |  |   |                                    |  |  |  |                                   | REG. NO.                                     |                   |  |
| 1. DECEASED NAME (TYPE OR PRINT)  |  |                              | FIRST MIDDLE LAST  |   |                                    | 2a. DATE OF DEATH  |  |  | MONTH DAY YEAR                    |  | 2b. HOUR          |  |
| Charles   |  |                              | F.. Sleeper  |   |                                    | 12 13 79   |  |  |                                   |  | 1 <sup>20</sup> M |  |
| 3. SEX  |  | 4. RACE                      |  | 5. DATE OF BIRTH  |                                    | 6. AGE (IN YEARS LAST BIRTHDAY)  |  | IF UNDER 1 YEAR  |                                   | IF UNDER 24 HRS                              |                   |  |
| Male  |  | White                        |  | 11-11-22 YEAR   |                                    | 67   |  | MONTHS DAYS  |                                   | HOURS MIN.                                   |                   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  | 7b. CITIZEN OF WHAT COUNTRY? |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                    | 9. BALTIMORE CITY OR COUNTY OF DEATH   |  |  |                                   |  |                   |  |
| Md.   |  | U.S.A.                       |  |   |                                    | Baltimore City MD.   |  |  |                                   |  |                   |  |
| 10. CITY OR TOWN OF DEATH   |  |                              | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |   |                                    | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY |  |                   |  |
| Baltimore   |  |                              | UNION MEMORIAL HOSPITAL  |   |                                    | Ret. Inspector   |  |  | Coppers Co.                       |  |                   |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |                              |  |   |                                    |  |  |  |                                   |  |                   |  |
| 13a. STATE  |  | 13b. COUNTY                  |  | 13c. CITY OR TOWN   |                                    | 13d. INSIDE CITY LIMITS?   |  | 13e. STREET ADDRESS  |                                   |  |                   |  |
| Md.   |  | BALTO.                       |  | Balto.  |                                    | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 600 So. Light St.  |                                   |  |                   |  |
| 14. FATHER'S NAME   |  |                              |  |   | 15. MOTHER'S MAIDEN NAME           |  |  |  |                                   |  |                   |  |
| FIRST MIDDLE LAST   |  |                              |  |   | FIRST MIDDLE LAST                  |  |  |  |                                   |  |                   |  |
| Charles F. Sleeper  |  |                              |  |   | Minerva Ruby                       |  |  |  |                                   |  |                   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)   |  |                              | 16b. SOCIAL SECURITY NO.   |   |                                    | 17. INFORMANT ADDRESS  |  |  |                                   |  |                   |  |
| No  |  |                              | 213-03-7346  |   |                                    | Charlotte Sleeper, 600 So. Light St.   |  |  |                                   |  |                   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |  |                              |  |   |                                    |  |  |  |                                   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |                   |  |
| PART I. DEATH WAS CAUSED BY:  |  |                              |  |   |                                    |  |  |  |                                   |  |                   |  |
| IMMEDIATE CAUSE (a) Cardio pulmonary arrest.  |  |                              |  |   |                                    |  |  |  |                                   |  |                   |  |
| 4273- DUE TO, OR AS A CONSEQUENCE OF  |  |                              |  |   |                                    |  |  |  |                                   |  |                   |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last   |  |                              |  |   |                                    |  |  |  |                                   |  |                   |  |
| DUE TO, OR AS A CONSEQUENCE OF  |  |                              |  |   |                                    |  |  |  |                                   |  |                   |  |
| (c)   |  |                              |  |   |                                    |  |  |  |                                   |  |                   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |                              |  |   |                                    |  |  |  |                                   |  |                   |  |
| Arteriosclerosis, the prostate to metastasize probable sepsis   |  |                              |  |   |                                    |  |  |  |                                   |  |                   |  |
| 19a. DATE OF OPERATION  |  |                              | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   |                                    | 20a. AUTOPSY?  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |                                   |  |                   |  |
|   |  |                              |  |   |                                    | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | YES <input type="checkbox"/> NO <input type="checkbox"/>       |                                   |  |                   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |                              | 21b. TIME OF INJURY  |   |                                    | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |  |                                   |  |                   |  |
|   |  |                              | HOUR A.M. MONTH DAY YEAR   |   |                                    |  |  |  |                                   |  |                   |  |
|   |  |                              | P.M. 19  |   |                                    |  |  |  |                                   |  |                   |  |
| 21d. INJURY OCCURRED  |  |                              | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |   |                                    | 21f. LOCATION  |  |  |                                   |  |                   |  |
| WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |                              |  |   |                                    | CITY OR TOWN COUNTY STATE  |  |  |                                   |  |                   |  |
| 22a. I certify that (this hospital) attended the deceased from 11/12, 19 79, to 12/13, 19 79, that (we) lost saw the deceased alive on 12/13, 19 79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) did not view the body after death. |  |                              |  |   |                                    |  |  |  |                                   |  |                   |  |
| 22b. SIGNATURE  |  |                              |  |   |                                    | DEGREE   |  |  | 22c. DATE SIGNED                  |  |                   |  |
| Joseph DiAntonio Jr. M.D.   |  |                              |  |   |                                    | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  |  | 12/13/79                          |  |                   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  |                              |  |   |                                    | 22e. ADDRESS   |  |  |                                   |  |                   |  |
| Joseph DiAntonio Jr. M.D.   |  |                              |  |   |                                    |  |  |  |                                   |  |                   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   |  |                              | 23b. DATE  |   | 23c. NAME OF CEMETERY OR CREMATORY |  |  | 23d. LOCATION  |                                   |  |                   |  |
| Burial  |  |                              | 12-17-79   |   | Oaklawn                            |  |  | Balto., COUNTY STATE   |                                   |  |                   |  |
|   |  |                              |  |   |                                    |  |  | Md.  |                                   |  |                   |  |
| 24. FUNERAL DIRECTOR  |  |                              |  |   |                                    | 25a. DATE REC'D. BY REGISTRAR  |  | 25b. REGISTRAR'S SIGNATURE                                     |                                   |  |                   |  |
| NAME ADDRESS  |  |                              |  |   |                                    |  |  |  |                                   |  |                   |  |
| Leonard J. Ruck, Inc., 5305 Harford Rd.   |  |                              |  |   |                                    | DEC 14 1979  |  | Anthony A. Crumley   |                                   |  |                   |  |





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page #

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

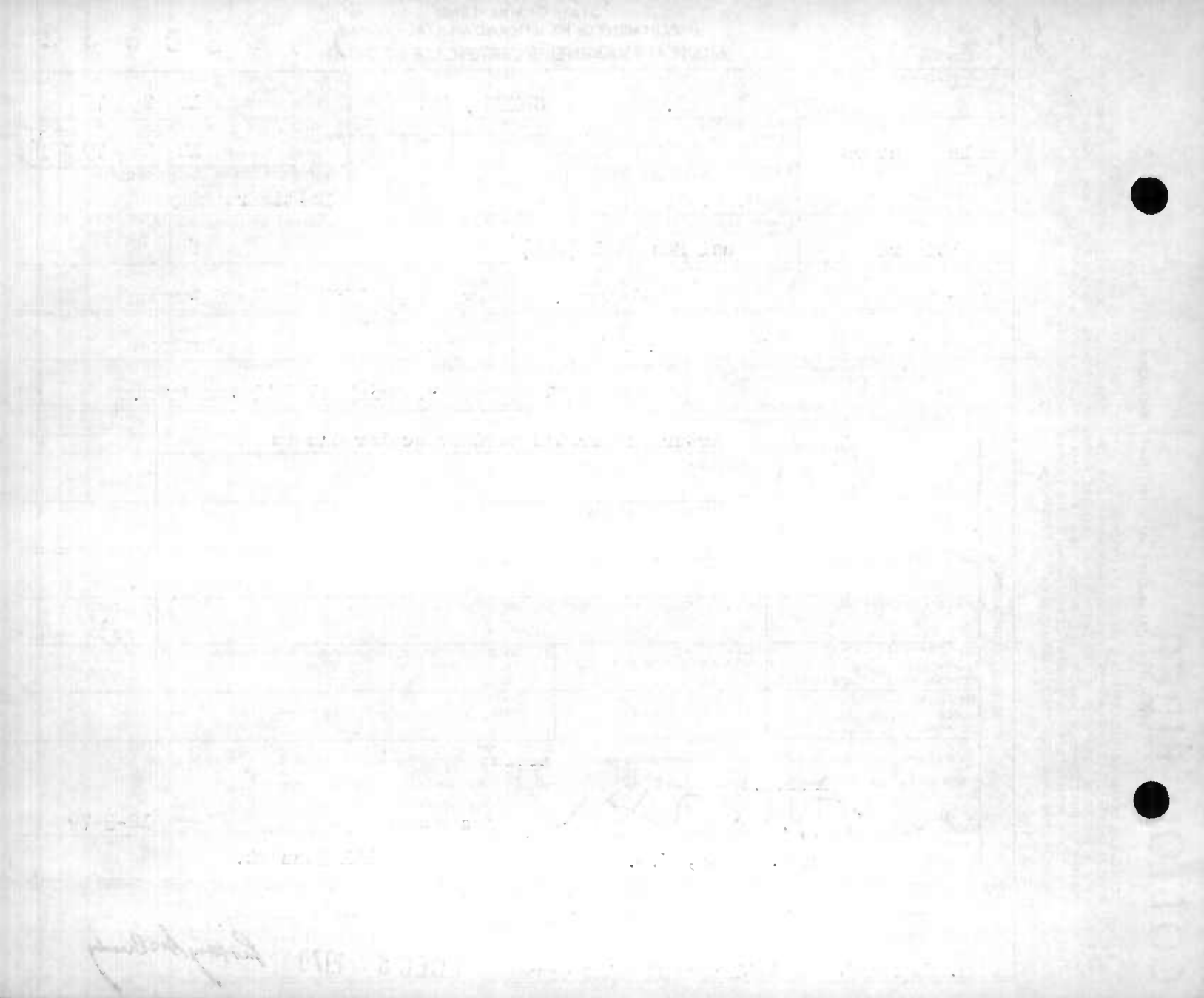
|   |  |  |   |
|---|--|--|---|
| 1. FOR STATE REGISTRAR <i>Amanda</i>  |  | 7 9 3 0 6 3 1  |   |
| 1. DECEASED NAME (TYPE OR PRINT) <i>Amanda C. Slowe</i>   |  | 2a. DATE OF DEATH MONTH DAY YEAR <i>12 11 79</i>   |   |
| 3. SEX <i>Female</i>  | 4. RACE <i>Negro</i>   | 5. DATE OF BIRTH MONTH DAY YEAR <i>5 14 1911</i>   | 6. AGE (IN YEARS (LAST BIRTHDAY)) <i>68</i> YRS MONTHS DAYS   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Maryland</i>   | 7b. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH <i>Balto, City</i> MD  |
| 10. CITY OR TOWN OF DEATH <i>Balto, City</i>  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Provident Hospital</i> | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  | 12b. KIND OF BUSINESS OR INDUSTRY   |
| 13a. STATE <i>Maryland</i>  | 13b. COUNTY  | 13c. CITY OR TOWN <i>Baltimore</i>   | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |
| 14. FATHER'S NAME FIRST MIDDLE LAST <i>Anthony</i>  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Florence McDowell</i>  | 13e. STREET ADDRESS <i>1110 Shellbanks Road</i>  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)   | 16b. SOCIAL SECURITY NO. <i>214-24-4418</i>  | 17. INFORMANT ADDRESS <i>Carlene Slowe 4928 Carmine Avenue</i>   |   |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>C.V.A.</i><br>436-<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <i>Uncontrolled Hypertension</i><br>(c) <i>Diabetes</i>           |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)   |  |  |   |
| 19a. DATE OF OPERATION  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <i>19</i>  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |   |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>11-06-79</i> to <i>12-11-79</i> , that (I) (we) last saw the deceased alive on <i>12-11-79</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |   |
| 22b. SIGNATURE <i>Maureen A. Allen, Jr. M.D.</i>  |  | DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>        | 22c. DATE SIGNED <i>12-11-79</i>  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  | 22e. ADDRESS   |   |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>   | 23b. DATE <i>12/15/1979</i>  | 23c. NAME OF CEMETERY OR CREMATORY <i>Mount Auburn Cemetery</i>  | 23d. LOCATION CITY OR TOWN COUNTY STATE <i>Baltimore, Maryland</i>  |
| 24. FUNERAL DIRECTOR NAME <i>Wm. C. March F/H</i> ADDRESS <i>1101 East North Avenue</i>   |  | 25a. DATE REC'D. BY REGISTRAR <i>DEC 12 1979</i>   | 25b. REGISTRAR'S SIGNATURE <i>Patricia McCreedy</i>   |

*[Faint, illegible handwriting]*

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. GIVE PAGES 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100, 101, 102, 103, 104, 105, 106, 107, 108, 109, 110, 111, 112, 113, 114, 115, 116, 117, 118, 119, 120, 121, 122, 123, 124, 125, 126, 127, 128, 129, 130, 131, 132, 133, 134, 135, 136, 137, 138, 139, 140, 141, 142, 143, 144, 145, 146, 147, 148, 149, 150, 151, 152, 153, 154, 155, 156, 157, 158, 159, 160, 161, 162, 163, 164, 165, 166, 167, 168, 169, 170, 171, 172, 173, 174, 175, 176, 177, 178, 179, 180, 181, 182, 183, 184, 185, 186, 187, 188, 189, 190, 191, 192, 193, 194, 195, 196, 197, 198, 199, 200, 201, 202, 203, 204, 205, 206, 207, 208, 209, 210, 211, 212, 213, 214, 215, 216, 217, 218, 219, 220, 221, 222, 223, 224, 225, 226, 227, 228, 229, 230, 231, 232, 233, 234, 235, 236, 237, 238, 239, 240, 241, 242, 243, 244, 245, 246, 247, 248, 249, 250, 251, 252, 253, 254, 255, 256, 257, 258, 259, 260, 261, 262, 263, 264, 265, 266, 267, 268, 269, 270, 271, 272, 273, 274, 275, 276, 277, 278, 279, 280, 281, 282, 283, 284, 285, 286, 287, 288, 289, 290, 291, 292, 293, 294, 295, 296, 297, 298, 299, 300, 301, 302, 303, 304, 305, 306, 307, 308, 309, 310, 311, 312, 313, 314, 315, 316, 317, 318, 319, 320, 321, 322, 323, 324, 325, 326, 327, 328, 329, 330, 331, 332, 333, 334, 335, 336, 337, 338, 339, 340, 341, 342, 343, 344, 345, 346, 347, 348, 349, 350, 351, 352, 353, 354, 355, 356, 357, 358, 359, 360, 361, 362, 363, 364, 365, 366, 367, 368, 369, 370, 371, 372, 373, 374, 375, 376, 377, 378, 379, 380, 381, 382, 383, 384, 385, 386, 387, 388, 389, 390, 391, 392, 393, 394, 395, 396, 397, 398, 399, 400, 401, 402, 403, 404, 405, 406, 407, 408, 409, 410, 411, 412, 413, 414, 415, 416, 417, 418, 419, 420, 421, 422, 423, 424, 425, 426, 427, 428, 429, 430, 431, 432, 433, 434, 435, 436, 437, 438, 439, 440, 441, 442, 443, 444, 445, 446, 447, 448, 449, 450, 451, 452, 453, 454, 455, 456, 457, 458, 459, 460, 461, 462, 463, 464, 465, 466, 467, 468, 469, 470, 471, 472, 473, 474, 475, 476, 477, 478, 479, 480, 481, 482, 483, 484, 485, 486, 487, 488, 489, 490, 491, 492, 493, 494, 495, 496, 497, 498, 499, 500, 501, 502, 503, 504, 505, 506, 507, 508, 509, 510, 511, 512, 513, 514, 515, 516, 517, 518, 519, 520, 521, 522, 523, 524, 525, 526, 527, 528, 529, 530, 531, 532, 533, 534, 535, 536, 537, 538, 539, 540, 541, 542, 543, 544, 545, 546, 547, 548, 549, 550, 551, 552, 553, 554, 555, 556, 557, 558, 559, 560, 561, 562, 563, 564, 565, 566, 567, 568, 569, 570, 571, 572, 573, 574, 575, 576, 577, 578, 579, 580, 581, 582, 583, 584, 585, 586, 587, 588, 589, 590, 591, 592, 593, 594, 595, 596, 597, 598, 599, 600, 601, 602, 603, 604, 605, 606, 607, 608, 609, 610, 611, 612, 613, 614, 615, 616, 617, 618, 619, 620, 621, 622, 623, 624, 625, 626, 627, 628, 629, 630, 631, 632, 633, 634, 635, 636, 637, 638, 639, 640, 641, 642, 643, 644, 645, 646, 647, 648, 649, 650, 651, 652, 653, 654, 655, 656, 657, 658, 659, 660, 661, 662, 663, 664, 665, 666, 667, 668, 669, 670, 671, 672, 673, 674, 675, 676, 677, 678, 679, 680, 681, 682, 683, 684, 685, 686, 687, 688, 689, 690, 691, 692, 693, 694, 695, 696, 697, 698, 699, 700, 701, 702, 703, 704, 705, 706, 707, 708, 709, 710, 711, 712, 713, 714, 715, 716, 717, 718, 719, 720, 721, 722, 723, 724, 725, 726, 727, 728, 729, 730, 731, 732, 733, 734, 735, 736, 737, 738, 739, 740, 741, 742, 743, 744, 745, 746, 747, 748, 749, 750, 751, 752, 753, 754, 755, 756, 757, 758, 759, 760, 761, 762, 763, 764, 765, 766, 767, 768, 769, 770, 771, 772, 773, 774, 775, 776, 777, 778, 779, 780, 781, 782, 783, 784, 785, 786, 787, 788, 789, 790, 791, 792, 793, 794, 795, 796, 797, 798, 799, 800, 801, 802, 803, 804, 805, 806, 807, 808, 809, 810, 811, 812, 813, 814, 815, 816, 817, 818, 819, 820, 821, 822, 823, 824, 825, 826, 827, 828, 829, 830, 831, 832, 833, 834, 835, 836, 837, 838, 839, 840, 841, 842, 843, 844, 845, 846, 847, 848, 849, 850, 851, 852, 853, 854, 855, 856, 857, 858, 859, 860, 861, 862, 863, 864, 865, 866, 867, 868, 869, 870, 871, 872, 873, 874, 875, 876, 877, 878, 879, 880, 881, 882, 883, 884, 885, 886, 887, 888, 889, 890, 891, 892, 893, 894, 895, 896, 897, 898, 899, 900, 901, 902, 903, 904, 905, 906, 907, 908, 909, 910, 911, 912, 913, 914, 915, 916, 917, 918, 919, 920, 921, 922, 923, 924, 925, 926, 927, 928, 929, 930, 931, 932, 933, 934, 935, 936, 937, 938, 939, 940, 941, 942, 943, 944, 945, 946, 947, 948, 949, 950, 951, 952, 953, 954, 955, 956, 957, 958, 959, 960, 961, 962, 963, 964, 965, 966, 967, 968, 969, 970, 971, 972, 973, 974, 975, 976, 977, 978, 979, 980, 981, 982, 983, 984, 985, 986, 987, 988, 989, 990, 991, 992, 993, 994, 995, 996, 997, 998, 999, 1000.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH   |  |   |  |   |  |                                   |  |                        |  | REG. NO. 9 30632                             |  |
|---|--|---|--|---|--|-----------------------------------|--|------------------------|--|--|--|
| 1. FOR STATE REGISTRAR  |  | 1. DECEASED NAME (TYPE OR PRINT)  |  | FIRST MIDDLE LAST   |  | 2a. DATE OF DEATH                 |  | KNOWN ESTIMATED        |  | 2b. HOUR                                     |  |
|   |  | ALFRED E. SMITH, Sr.  |  |   |  | 12 2 19 79                        |  |                        |  | M  |  |
| 3. SEX  |  | 4. RACE   |  | 5. DATE OF BIRTH  |  | 6. AGE (IN YEARS)                 |  | IF UNDER 1 YR.         |  | IF UNDER 24 HRS.                             |  |
| male  |  | negro   |  | 2 8 28  |  | 51 YRS.                           |  | MONTHS DAYS HOURS MIN. |  | 2c. DATE PRONOUNCED DEAD                     |  |
|   |  |   |  |   |  |                                   |  |                        |  | 12 2 19 79                                   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  | 7b. CITIZEN OF WHAT COUNTRY?  |  | 8. MARRIED  |  | NEVER MARRIED                     |  | WIDOWED                |  | 9. BALTIMORE CITY OR COUNTY OF DEATH         |  |
| Maryland  |  | U. S. A.  |  | X   |  |                                   |  |                        |  | Baltimore City MD.                           |  |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) |  | 12b. KIND OF BUSINESS OR INDUSTRY |  |                        |  |  |  |
| Baltimore   |  | Sinai Hospital (DOA)  |  |   |  |                                   |  |                        |  |  |  |
| 13a. STATE  |  | 13b. COUNTY   |  | 13c. CITY OR TOWN   |  | 13d. INSIDE CITY LIMITS?          |  | 13e. STREET ADDRESS    |  |  |  |
| Maryland  |  |   |  | Baltimore   |  | YES X NO                          |  | 3207 Woodland Avenue   |  |  |  |
| 14. FATHER'S NAME   |  | 15. MOTHER'S MAIDEN NAME  |  |   |  |                                   |  |                        |  |  |  |
| Archen J. Smith   |  | Frances Turner  |  |   |  |                                   |  |                        |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)  |  | 16b. SOCIAL SECURITY NO.  |  | 17. INFORMANT   |  | ADDRESS                           |  |                        |  |  |  |
| No  |  | 219-22-2173   |  | Ruth E. Smith   |  | 1708 Thomas Avenue                |  |                        |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |  |   |  |   |  |                                   |  |                        |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease   |  |   |  |   |  |                                   |  |                        |  |  |  |
| 4292  |  |   |  |   |  |                                   |  |                        |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF  |  |   |  |   |  |                                   |  |                        |  |  |  |
| (b)   |  |   |  |   |  |                                   |  |                        |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF  |  |   |  |   |  |                                   |  |                        |  |  |  |
| (c)   |  |   |  |   |  |                                   |  |                        |  |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).                           |  |   |  |   |  |                                   |  |                        |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |  |   |  |                                   |  | 20. AUTOPSY?           |  |  |  |
|   |  |   |  |   |  |                                   |  | YES X NO               |  |  |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH   |  | 21b. TIME OF INJURY   |  | 21c. HOW INJURY OCCURRED                                      |  |                                   |  |                        |  |  |  |
|   |  | HOUR A.M. MONTH DAY YEAR  |  | ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2            |  |                                   |  |                        |  |  |  |
|   |  | P.M. 19   |  |   |  |                                   |  |                        |  |  |  |
| 21d. INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)   |  | 21f. LOCATION   |  |                                   |  |                        |  |  |  |
|   |  |   |  | STREET CITY OR TOWN COUNTY STATE                              |  |                                   |  |                        |  |  |  |
| 22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes X Accident Suicide Homicide Undetermined manner |  |   |  |   |  |                                   |  |                        |  |  |  |
| TITLE (SPECIFY) Assistant MEDICAL EXAMINER DATE SIGNED 12-3-79  |  |   |  |   |  |                                   |  |                        |  |  |  |
| ACTUAL SIGNATURE  |  | EXAMINER'S NAME (TYPE OR PRINT)   |  | ADDRESS   |  |                                   |  |                        |  |  |  |
|   |  | Ann M. Dixon, M.D.  |  | 111 Penn St.  |  |                                   |  |                        |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   |  | 23b. DATE   |  | 23c. NAME OF CEMETERY OR CREMATORY                            |  | 23d. LOCATION                     |  |                        |  |  |  |
| Burial  |  | 12/6/1979   |  | King Mem. Park  |  | Baltimore Co., Md.                |  |                        |  |  |  |
| 24. FUNERAL DIRECTOR  |  | 25a. DATE REC'D. BY REGISTRAR   |  | 25b. REGISTRAR'S SIGNATURE                                    |  |                                   |  |                        |  |  |  |
| NAME ADDRESS  |  | DEC 6 1979  |  | History McCreedy  |  |                                   |  |                        |  |  |  |
| Wm. C. March F/H 1101 East North Avenue   |  |   |  |   |  |                                   |  |                        |  |  |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  |   |  |   |  |                                |  | 7 9 3 0 6 3 3    |     |   |          |  |
|--|--|--|--|---|--|---|--|--------------------------------|--|------------------|-----|---|----------|--|
| 1. FOR<br>STATE<br>REGISTRAR   |  | REG. NO.   |  |   |  |   |  |                                |  |                  |     |   |          |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  | FIRST  |  | MIDDLE  |  | LAST  |  | 2a. DATE OF DEATH              |  | MONTH            | DAY | YEAR  | 2b. HOUR |  |
| Bernell B. Smith   |  |  |  |   |  |   |  | 12/10/79                       |  |                  |     |   | 6:15 AM  |  |
| 3. SEX   |  | 4. RACE  |  | 5. DATE OF BIRTH  |  | 6. AGE (IN YEARS LAST BIRTHDAY)                                     |  | IF UNDER 1 YEAR                |  | IF UNDER 24 HRS  |     |   |          |  |
| Female   |  | Black  |  | 3 12 1909   |  | 70 YRS  |  | MONTHS                         |  | DAYS             |     | HOURS MIN                                       |          |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN<br>COUNTRY)  |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |  |                                |  |                  |     |   |          |  |
| Maryland   |  | USA  |  |   |  | Baltimore   |  | MD.                            |  |                  |     |   |          |  |
| 10. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT INSUCH FACILITY, GIVE STREET ADDRESS) |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)  |  | 12b. KIND OF BUSINESS OR<br>INDUSTRY                                |  |                                |  |                  |     |   |          |  |
| Baltimore  |  | Parkhill Nursing Home  |  | Housewife   |  |   |  |                                |  |                  |     |   |          |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  | 13b. COUNTY  |  | 13c. CITY OR TOWN   |  | 13d. INSIDE CITY LIMITS?  |  | 13e. STREET ADDRESS            |  |                  |     |   |          |  |
| Maryland   |  |  |  | Baltimore   |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 111 Center Street              |  |                  |     |   |          |  |
| 14. FATHER'S NAME  |  | 15. MOTHER'S MAIDEN NAME   |  | 16. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)   |  | 16b. SOCIAL SECURITY NO.  |  | 17. INFORMANT                  |  | ADDRESS          |     |   |          |  |
| Arthur   |  | Irene  |  | No  |  | 215-22-7383   |  | Martha Smith                   |  | 1041 Harlem Ave. |     |   |          |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY  |  | IMMEDIATE CAUSE (a)  |  | DUE TO, OR AS A CONSEQUENCE OF  |  | (b)   |  | DUE TO, OR AS A CONSEQUENCE OF |  | (c)              |     | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |          |  |
| 1629   |  | Right upper lobe bronchogenic carcinoma  |  |   |  |   |  |                                |  |                  |     |   |          |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |  |  |   |  |   |  |                                |  |                  |     |   |          |  |
| ① Hypertension ② Chronic Degenerative process  |  |  |  |   |  |   |  |                                |  |                  |     |   |          |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?   |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?   |  |                                |  |                  |     |   |          |  |
| 9/78   |  | Bronchogenic carcinoma   |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | YES <input type="checkbox"/> NO <input type="checkbox"/>            |  |                                |  |                  |     |   |          |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |                                |  |                  |     |   |          |  |
|  |  | P.M. 19  |  |   |  |   |  |                                |  |                  |     |   |          |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                   |  | 21f. LOCATION<br>STREET   |  | CITY OR TOWN  |  | COUNTY                         |  | STATE            |     |   |          |  |
|  |  |  |  |   |  |   |  |                                |  |                  |     |   |          |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 10-24 19 79, to 12-10 19 79, that (I) (we) lost<br>saw the deceased alive on 12-10 19 79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death. |  |  |  |   |  |   |  |                                |  |                  |     |   |          |  |
| 22b. SIGNATURE   |  | DEGREE   |  | ATTENDING<br>PHYSICIAN <input checked="" type="checkbox"/> MEDICAL<br>DIRECTOR <input type="checkbox"/> STAFF<br>PHYSICIAN <input type="checkbox"/>         |  | 22c. DATE SIGNED  |  |                                |  |                  |     |   |          |  |
| Johnny Eufemio, M.D.   |  |  |  |   |  | 12-10-79  |  |                                |  |                  |     |   |          |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  | 22e. ADDRESS   |  |   |  |   |  |                                |  |                  |     |   |          |  |
| JOHNNY EUFEMIO, M.D.   |  | 1133 PENNSYLVANIA AVE., BALTO, MD. 21201   |  |   |  |   |  |                                |  |                  |     |   |          |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)   |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY  |  | 23d. LOCATION<br>CITY OR TOWN                                       |  | COUNTY                         |  | STATE            |     |   |          |  |
| Burial   |  | 12/15/1979   |  | Arbutus Memorial Park   |  | Arbutus   |  | Maryland                       |  |                  |     |   |          |  |
| 24. FUNERAL DIRECTOR<br>NAME   |  | ADDRESS  |  | 25a. DATE REC'D. BY REGISTRAR   |  | 25b. REGISTRAR'S SIGNATURE  |  |                                |  |                  |     |   |          |  |
| Wm. C. March F/H 1101 East North Avenue  |  |  |  | DEC 11 1979   |  | Johnny McCreedy   |  |                                |  |                  |     |   |          |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  | 7-9 30634<br>REG. NO.   |  |  |  |
|--|--|---|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>C. Gerard SMITH   |  |   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>DECEMBER 12, 1979  |  |  |  |
| 1. SEX<br>Male   |  | 4. RACE<br>White  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>June 22, 1895   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>84 YRS.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore County MD.   |  |
| 10. CITY OR TOWN OF DEATH<br>Lutherville   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>College Manor Nursing Home |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Management  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>E.F. Hutton Co.   |  |
| 13a. STATE<br>Pennsylvania   |  | 13b. COUNTY<br>Port Royal   |  | 13c. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 13d. STREET ADDRESS<br>Unknown   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Judson E. Smith  |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Unknown  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>Yes  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>WW I 215 03 5525   |  | 17. INFORMANT<br>ADDRESS<br>C. Fenner Goldsborough Balto., Md.  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY.<br>IMMEDIATE CAUSE (a) <u>Carcinoma of Hypopharynx</u><br><u>1489</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>metastases</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u></u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |   |  |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)  |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |
| 22a. I certify that (I) (the hospital) attended the deceased from <u>Feb 5th</u> 19 <u>79</u> , to <u>Dec 12th</u> 19 <u>79</u> , that (I) (we) lost saw the deceased alive on <u>Dec 10th</u> 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.                             |  |   |  |   |  |  |  |
| 22b. SIGNATURE<br><u>Kevin Quinn</u>   |  |   |  | DEGREE<br><u>MD</u>   |  | 22c. DATE SIGNED<br><u>12/13/79</u>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Dr. Kevin Quinn, M.D.   |  |   |  | 22e. ADDRESS<br>1205 York Road Lutherville, Md.   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial  |  | 23b. DATE<br>12/19/79   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Westminster Church  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Mifflintown, Pa.   |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br>Henry W. Jenkins & Sons Co.<br>4905 York Road Balto., Md. 21212  |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br>DEC 20 1979  |  |  |  |
|  |  |   |  | 25b. REGISTRAR'S SIGNATURE<br><u>Robert McCreedy</u>  |  |  |  |

DEC 9 1952

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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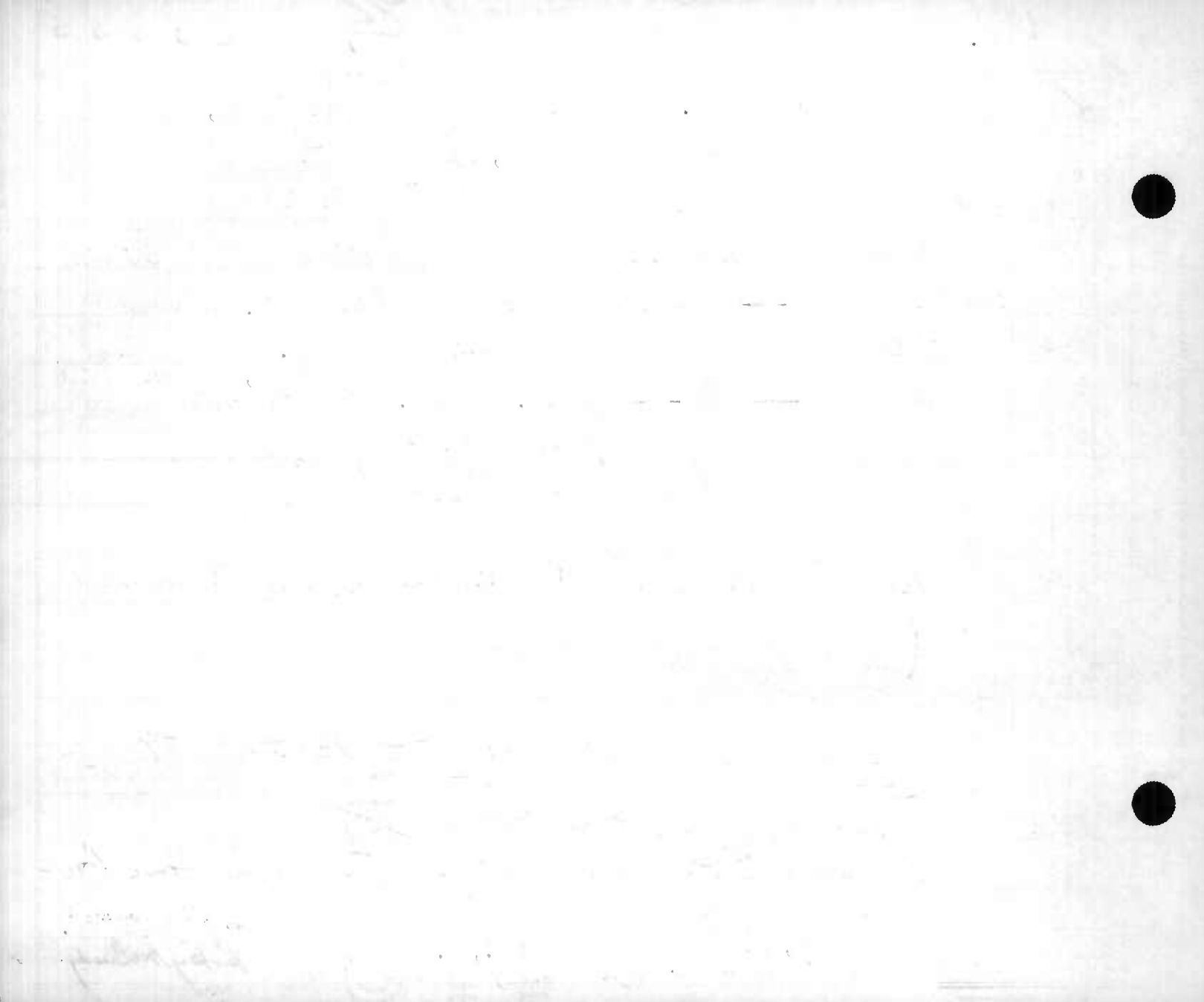
FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

7 9 3 0 6 3 5

REG. NO.

|  |  |   |  |   |   |   |  |   |   |
|--|--|---|--|---|---|---|--|---|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Charles A. Smith  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>December 12, 1979               |   |   | 2b. HOUR<br>M   |  |   |   |
| 3. SEX<br>Male   |  | 4. RACE<br>White  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>May 25, 1905  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>74 YRS.  |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.  |   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.  |  |   |   |
| 10. CITY OR TOWN OF DEATH<br>Baltimore   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>6211 Pennington Avenue |  |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Builder   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Shipping   |   |
| 13a. STATE<br>Maryland   |  | 13b. COUNTY<br>---  |  | 13c. CITY OR TOWN<br>Baltimore  |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 13e. STREET ADDRESS<br>6211 Pennington Avenue   |   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Willis Smith   |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Julia A. Ross  |   |   |  |   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>NO   |  | 16b. SOCIAL SECURITY NO.<br>218-28-0222   |  | 17. INFORMANT<br>ADDRESS<br>Baltimore, Maryland 21226<br>Mr. Joseph G. Smith 6211 Pennington Avenue   |   |   |  |   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) 185- Pneumonia<br>(b) DUE TO, OR AS A CONSEQUENCE OF Metastatic Prostate Cancer<br>(c) DUE TO, OR AS A CONSEQUENCE OF<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br>Arteriosclerotic Cardiovascular Disease |  |   |  |   |   |   |  |   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |
| 19a. DATE OF OPERATION   |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |   |
| 22a. I certify that (I) (this hospital) attended the deceased from March 19 74 to 12-Dec 19 79, that (I) (we) lost saw the deceased alive on 12-Dec 19 79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |   |  |   |   |   |  |   |   |
| 22b. SIGNATURE<br>Richard E. Fishen MD   |  |   |  |   |   | 22c. DATE SIGNED  |  | 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Richard E. Fishen  |   |
| 22e. ADDRESS<br>4700 Pennington Ave  |  |   |  |   |   | 22f. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  |   |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial   |  |   | 23b. DATE<br>12/15/79  |   | 23c. NAME OF CEMETERY OR CREMATORY<br>Cedar Hill Cemetery |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore Anne Arundel Md. |   |   |
| 24. FUNERAL DIRECTOR<br>NAME<br>Mc Cully Funeral Home of Brooklyn  |  |   |  |   |   | 25a. DATE REC'D. BY REGISTRAR<br>21225  |  | 25b. REGISTRAR'S SIGNATURE<br>DEC 17 1979   |   |





FOR  
1 - STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |   |   |  |  |
|---|--|---|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Elsie Lee SMITH</b>  |  |   | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>12 - 10 79</b>   |  | 2b. HOUR<br><b>1:50 AM</b>   |
| 3. SEX<br><b>Female</b>   | 4. RACE<br><b>Negroid</b>  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>7-25-24</b>  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>55</b> YRS                               |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Md.</b>   | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.              |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTO. CITY</b>   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>PROVIDENT HOSPITAL</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Federal Government</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY  |
| 13a. STATE<br><b>Md.</b>  |  |   | 13b. COUNTY<br><b>BALTO.</b>  | 13c. CITY OR TOWN<br><b>BALTO.</b>   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Samuel Smith</b>   |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Suzey Jackson</b>                         |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>220-20-8080</b>   |   | 17. INFORMANT<br>ADDRESS<br><b>Patrica Robinson</b>                            |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiac arrest</b><br><b>2500</b> DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>Diabetes Mellitus</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) |  |   |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).   |  |   |   |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>      | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2) |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>12-07-79</b> to <b>12-10-79</b> , that (I) (we) last saw the deceased alive on <b>12-10-79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |   |   |  |  |
| 22b. SIGNATURE<br><b>H Nazer MD</b>   |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>        |   | 22c. DATE SIGNED<br><b>12/10/79</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>HUSAM NAZER, M.D.</b>   |  | 22e. ADDRESS<br><b>Provident Hospital</b>   |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>12-13-79</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>WESTERN STAR</b>                      |  |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>BALTO MD</b>   |  | 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>V. Bailey 1548 Calhoun St.</b>   |   |  |  |
| 25a. DATE REC'D. BY REGISTRAR<br><b>DEC 12 1979</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>Robert M. Bailey</b>   |   |  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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*[Handwritten signature or initials.]*

ABCT 1101

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

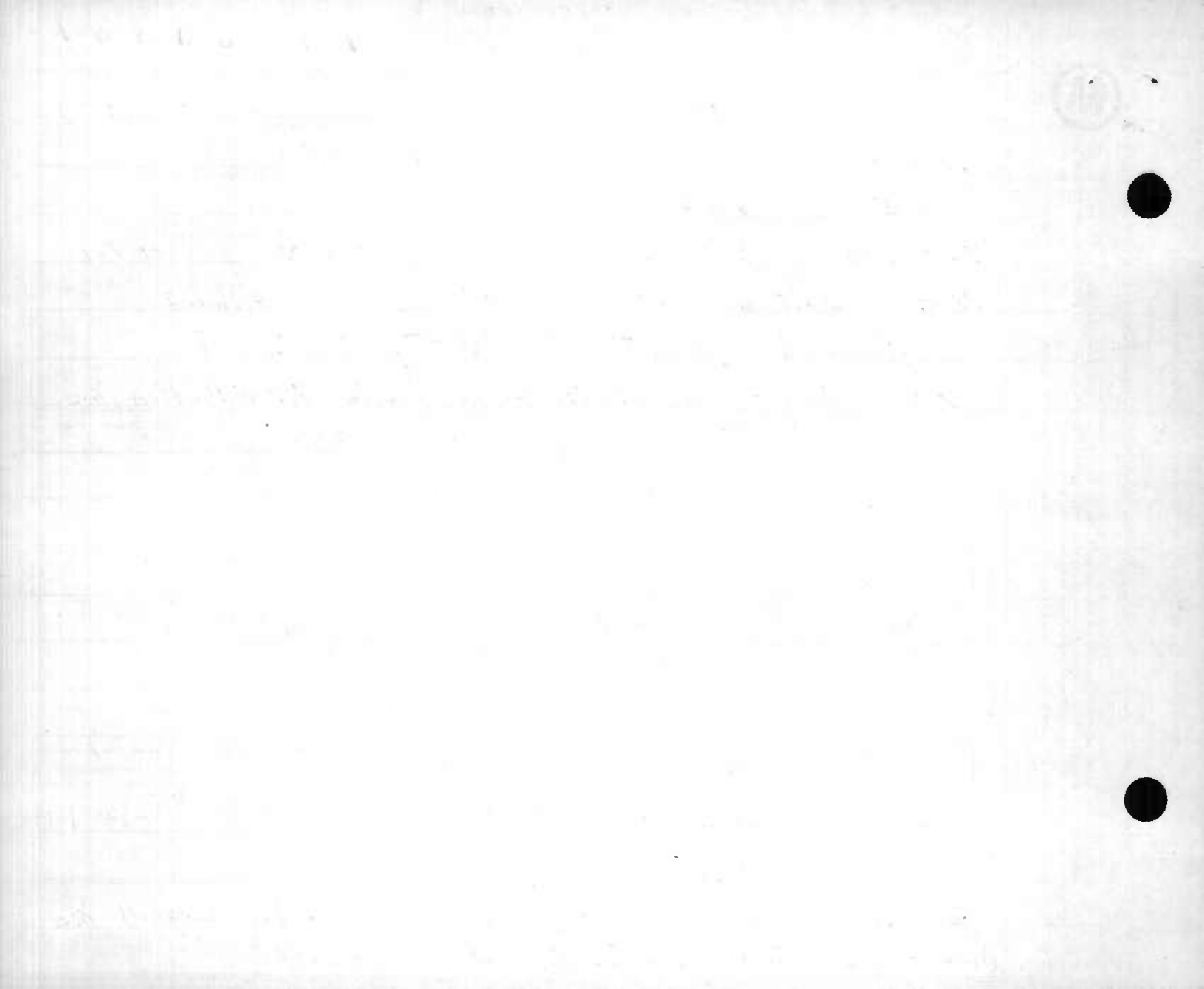
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

7930637  
REG. NO.

|  |  |  |   |   |  |   |  |                        |  |  |  |
|--|--|--|---|---|--|---|--|------------------------|--|--|--|
| 1. FOR STATE REGISTRAR   |  |  | 2a. DATE OF DEATH   |   |  | 2b. HOUR  |  |                        |  |  |  |
| 1. DECEASED NAME (TYPE OR PRINT)   |  |  | 2a. DATE OF DEATH   |   |  | 2b. HOUR  |  |                        |  |  |  |
| FIRST MIDDLE LAST<br>George H Smith  |  |  | MONTH DAY YEAR<br>12-20-79  |   |  | 4:30 A.M.   |  |                        |  |  |  |
| 3. SEX   |  | 4. RACE  |   | 5. DATE OF BIRTH  |  | 6. AGE (IN YEARS LAST BIRTHDAY)                                   |  | 7. IF UNDER 1 YEAR     |  |  |  |
| MALE   |  | BLACK  |   | MONTH DAY YEAR<br>3 15 1919   |  | 60 YRS.   |  | MONTHS DAYS HOURS MIN. |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  | 7b. CITIZEN OF WHAT COUNTRY?   |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                              |  |                        |  |  |  |
| Md   |  | USA  |   |   |  | City  |  |                        |  |  |  |
| 10. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)   |  | 12b. KIND OF BUSINESS OR INDUSTRY                                 |  |                        |  |  |  |
| Baltimore  |  | SUTHERAN   |   | Cook  |  | Hotel   |  |                        |  |  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |  | 13b. INSIDE CITY LIMITS?  |   |  | 13c. STREET ADDRESS   |  |                        | 13d. CITY OR TOWN  |  |  |
| 13a. STATE COUNTY<br>Md Baltimore  |  |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |   |  | Gilmore   |  |                        | Baltimore  |  |  |
| 14. FATHER'S NAME  |  |  | 15. MOTHER'S MAIDEN NAME  |   |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) |  |                        | 16b. SOCIAL SECURITY NO.   |  |  |
| FIRST MIDDLE LAST<br>Richard Smith   |  |  | FIRST MIDDLE LAST<br>Betty Smith  |   |  | 16a. NONE   |  |                        | 217-07-7313  |  |  |
| 17. INFORMANT  |  |  | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |   |  | 19. DATE OF OPERATION   |  |                        | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                               |  |  |
| George Smith   |  |  | 18. PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cardio-respiratory arrest-<br>1459<br>DUE TO, OR AS A CONSEQUENCE OF (b) Terminal carcinoma - Mouth<br>DUE TO, OR AS A CONSEQUENCE OF (c)<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) None |   |  | None  |  |                        | N/A  |  |  |
| 17. INFORMANT ADDRESS  |  |  | 19. DATE OF OPERATION   |   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                  |  |                        | 20a. AUTOPSY?  |  |  |
| New Windsor, Md  |  |  | None  |   |  | N/A   |  |                        | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  |  |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?   |  |  | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |   |  | 21b. TIME OF INJURY   |  |                        | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |  |
| YES <input type="checkbox"/> NO <input type="checkbox"/>   |  |  |   |   |  | HOUR A.M. MONTH DAY YEAR<br>P.M. 19                               |  |                        |  |  |  |
| 21a. INJURY OCCURRED   |  |  | 21b. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |   |  | 21c. LOCATION   |  |                        | 21d. CITY OR TOWN  |  |  |
| WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  |  |   |   |  | STREET  |  |                        | COUNTY STATE   |  |  |
| 22a. certify that I (this hospital) attended the deceased from 11/1/79, 19, to 12/20/79, 19, that I (we) last saw the deceased alive on 12/20/79, 19, and that in my (our) opinion death occurred on the date and hour and from the causes stated above, and I (we) did not view the body after death. |  |  | 22b. SIGNATURE  |   |  | 22c. DATE SIGNED  |  |                        | 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  |  |
|  |  |  | R. Thiaga Rajan   |   |  | 12/20/79  |  |                        | R. THIAGARAJAN M.D.  |  |  |
| 22b. SIGNATURE   |  |  | 22c. DATE SIGNED  |   |  | 22d. PHYSICIAN'S NAME (TYPE OR PRINT)                             |  |                        | 22e. ADDRESS   |  |  |
| R. Thiaga Rajan  |  |  | 12/20/79  |   |  | R. THIAGARAJAN M.D.   |  |                        |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |  |  | 23b. DATE   |   |  | 23c. NAME OF CEMETERY OR CREMATORY                                |  |                        | 23d. LOCATION  |  |  |
| Burial   |  |  | 12-22-79  |   |  | ELERYGREEN  |  |                        | Finksburg, Maryland  |  |  |
| 24. FUNERAL DIRECTOR   |  |  | 25a. DATE REC'D. BY REGISTRAR   |   |  | 25b. REGISTRAR'S SIGNATURE  |  |                        | 25c. REGISTRAR'S NAME  |  |  |
| Robert Kyle Prutts Jr.   |  |  | JAN 2 1980  |   |  | Robert Kyle Prutts Jr.  |  |                        | Robert Kyle Prutts Jr.   |  |  |





STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

7 9 3 0 6 3 8

1- FOR  
STATE  
REGISTRAR

REG. NO.

|   |  |  |  |   |  |  |  |  |  |  |                                       |  |
|---|--|--|--|---|--|--|--|--|--|--|---------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>JOHNNIE L/ SMITH</b>  |  |  | 2a. DATE OF DEATH<br>MONTH <b>12</b> DAY <b>12</b> YEAR <b>79</b>                                |   |  | 2b. HOUR<br><b>7:20A</b> M   |  |  |  |  |                                       |  |
| 3. SEX<br><b>MALE</b>   |  | 4. RACE<br><b>BLACK</b>  |  | 5. DATE OF BIRTH<br>MONTH <b>1</b> DAY <b>7</b> YEAR <b>40</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>39</b> <del>42</del> <sup>6</sup> YRS  |  | IF UNDER 1 YEAR<br>MONTHS <b>4</b> DAYS <b>8</b>   |  | IF UNDER 24 HRS<br>HOURS <b>0</b> MIN <b>0</b>                               |                                       |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>BRONX, N.Y.</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD   |  |  |  |  |                                       |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>VA MEDICAL CENTER BALTO, MD.</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK OR MOST OF WORKING LIFE)<br><b>Laborer</b>  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>0-----</b>                       |  |                                       |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |  |  |   |  | 13a. STATE<br><b>MARYLAND</b>  |  |  | 13b. COUNTY  |  | 13c. CITY OR TOWN<br><b>BALTIMORE</b> |  |
| 14. FATHER'S NAME<br>FIRST <b>Raul</b> MIDDLE <b>Smith</b> LAST   |  |  |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>Lucille</b> MIDDLE <b>Coan</b> LAST   |  |  |  |  |                                       |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>YES</b>  |  |  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>1960 -1962</b>  |  | 17. INFORMANT<br><b>Elder Smith</b>  |  | ADDRESS<br><b>704 N. Gilman St.</b>  |  |  |                                       |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <b>Cardiogenic shock</b><br><b>4560</b> DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <b>Reversible myocardial infarction</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) |  |  |  |   |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>1 day</b><br><b>1 day</b> |                                       |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><b>Esophageal varices, Hepatic cirrhosis</b>   |  |  |  |   |  |  |  |  |  |  |                                       |  |
| 19a. DATE OF OPERATION<br><b>12/9/79</b>  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>Bleeding esophageal varices/gastritis</b> |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |                                       |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                       |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |  |  |  |                                       |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                           |   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |  |  |  |                                       |  |
| 22a. I certify that (X) (this hospital) attended the deceased from <b>DEC. 5,</b> 19 <b>79</b> to <b>DEC. 12,</b> 19 <b>79</b> , that (X) (we) lost<br>saw the deceased alive above <b>DEC. 12,</b> 19 <b>79</b> , and that in (m) (our) opinion death occurred on the date and hour and from the causes stated<br>above (X) (we) (did) (not) view the body after death.                    |  |  |  |   |  |  |  |  |  |  |                                       |  |
| 22b. SIGNATURE<br><b>Brian Benner MD</b>  |  |  |  |   |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br><b>12/12/79</b>  |  |  |                                       |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>BRIAN BENNER MD</b>   |  |  |  |   |  | 22e. ADDRESS<br><b>3900 LOCH RAVEN BLVD. BALTIMORE, MD. 18</b>   |  |  |  |  |                                       |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   |  |  | 23b. DATE<br><b>12/13/79</b>   |   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Westview</b>  |  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore, Maryland</b> |  |                                       |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Law Funeral Home 4611 Park Height Ave.</b>   |  |  |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>DEC 18 1979</b>  |  |  | 25b. REGISTRAR'S SIGNATURE<br><i>Anthony McCreedy</i>                    |  |                                       |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified (MD-0007).

1. The first step is to identify the problem or question that needs to be answered. This involves understanding the context and the specific requirements of the task.

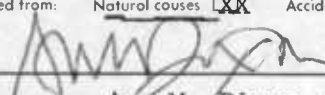

27/21/1 10100

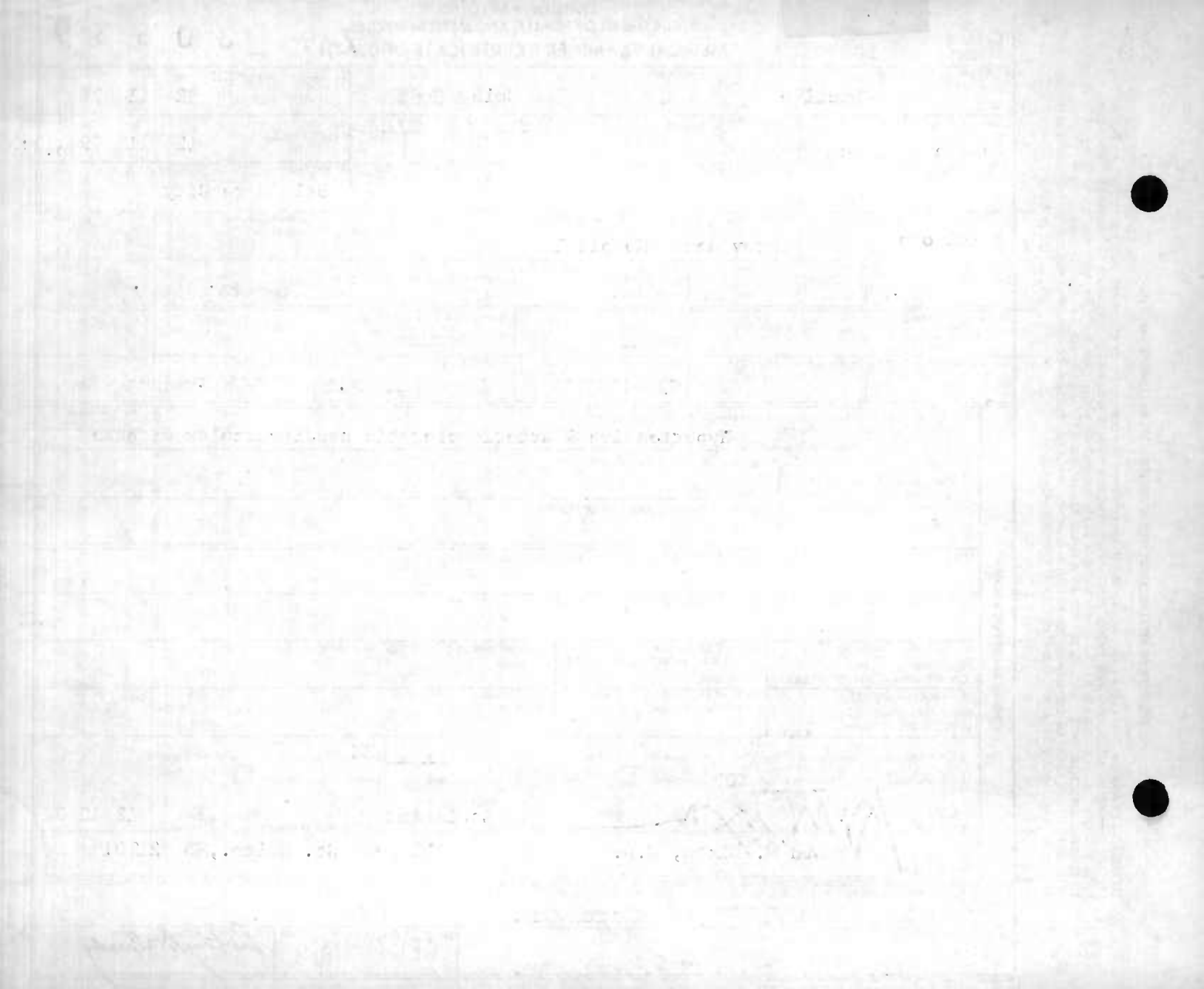
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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |  |  |  |   |  |   |  |   |                                   | REG. NO. 30639   |  |
|--|--|--|--|---|--|---|--|---|-----------------------------------|--|--|
| 1. FOR STATE REGISTRAR   |  | 1. DECEASED NAME<br>(TYPE OR PRINT) FIRST MIDDLE LAST<br>Lucille F. Cole Smith   |  |   |  |   |  | 2a. DATE KNOWN OF DEATH<br>ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR<br>12 11 79 |                                   | 2b. HOUR<br>M<br>AM                                    |  |
| 3. SEX<br>female   |  | 4. RACE<br>black   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>4 11 11   |  | 6. AGE (IN YEARS)<br>LAST BIRTHDAY<br>68 YRS.   |  | IF UNDER 1 YR.<br>MONTHS DAYS HOURS MIN.  |                                   | 7c. DATE PRONOUNCED DEAD<br>MONTH DAY YEAR<br>12 11 79 |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Va.   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.  |  |   |                                   |  |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore   |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Provident Hospital |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)   |  |   | 12b. KIND OF BUSINESS OR INDUSTRY |  |  |
| 13a. STATE<br>Md.  |  | 13b. COUNTY  |  | 13c. CITY OR TOWN<br>Balto.   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                     |  | 13e. STREET ADDRESS<br>3400 Powhatan Avenue   |                                   |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Germay Fowlkes   |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Fannie   |  |   |  |   |                                   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br>No  |  | (IF YES, GIVE WAR OR DATES)  |  | 16b. SOCIAL SECURITY NO.<br>219-12-7128   |  | 17. INFORMANT<br>Joseph S. Smith  |  | ADDRESS<br>3400 Powhatan Ave.   |                                   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1 DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Hypertensive &amp; Arteriosclerotic cardiovascular disease</u><br>4029<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____                                       |  |  |  |   |  |   |  |   |                                   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH           |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).  |  |  |  |   |  |   |  |   |                                   |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |  |   |  |   |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                 |                                   |  |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |  |   |  |   |                                   |  |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |   |                                   |  |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |  |  |  |   |  |   |  |   |                                   |  |  |
| ACTUAL SIGNATURE<br>  |  | TITLE (SPECIFY)<br>Assistant   |  |   |  | DATE SIGNED<br>12/12/79   |  |   |                                   |  |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT)<br>Ann M. Dixon, M.D.   |  | ADDRESS<br>111 Penn St. Balto., MD 21201   |  |   |  |   |  |   |                                   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial   |  | 23b. DATE<br>12/15/79  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Church Cem.   |  | 23d. LOCATION<br>CITY OR TOWN<br>Crewe, Va.   |  | COUNTY STATE  |                                   |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Wm C March F/H   |  | ADDRESS<br>1101 E. North Ave.  |  | 25a. DATE REC'D. BY REGISTRAR<br>DEC 13 1979  |  | 25b. REGISTRAR'S SIGNATURE<br> |  |   |                                   |  |  |



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |         |  |  |   |  |   |  |   |  | REG. NO. 30640  |  |
|--|---------|--|--|---|--|---|--|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |         | FIRST  |  | MIDDLE  |  | LAST  |  | 2a. DATE OF DEATH<br>KNOWN <input checked="" type="checkbox"/> ESTIMATED <input type="checkbox"/> |  | 2b. HOUR  |  |
| Matthew  |         | Smith  |  | Sr.   |  |   |  | 12 4 19 79  |  | M   |  |
| 3. SEX   | 4. RACE | 5. DATE OF BIRTH<br>MONTH DAY YEAR   |  | 6. AGE (IN YEARS)<br>LAST BIRTHDAY YRS.   |  | 7. IF UNDER 1 YR.<br>MONTHS DAYS  |  | 8. IF UNDER 24 HRS.<br>HOURS MIN  |  | 2c. DATE PRONOUNCED DEAD  |  |
| male   | black   | 10 25 09   |  | 70  |  |   |  |   |  | 12 4 19 79 2:00 P.M.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |         | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH  |  |   |  |   |  |
| Virginia   |         | U. S. A.   |  |   |  | Baltimore City MD.  |  |   |  |   |  |
| 10. CITY OR TOWN OF DEATH  |         | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |   |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                                     |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |
| Baltimore  |         | Lutheran Hospital  |  |   |  |   |  |   |  |   |  |
| 13a. STATE   |         | 13b. COUNTY  |  | 13c. CITY OR TOWN   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS   |  |   |  |
| Maryland   |         |  |  | Baltimore   |  |   |  | 509 Poplar Grove  |  |   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST   |         |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE  |  |   |  |   |  |   |  |
| John Smith   |         |  |  | Mattie Smith  |  |   |  |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)  |         |  |  | 16b. SOCIAL SECURITY NO.  |  | 17. INFORMANT ADDRESS   |  |   |  |   |  |
|  |         |  |  | 215-03-4331   |  | Constance Floyd 4020 Edgewood Road  |  |   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>5711 IMMEDIATE CAUSE (a) <u>Alcoholic hepatitis</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the <u>underlying</u> cause lost.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____  |         |  |  |   |  |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).  |         |  |  |   |  |   |  |   |  |   |  |
| 19a. DATE OF OPERATION   |         |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |  |   |  |   |  | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |         |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)                   |  |   |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |         |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |   |  |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |         |  |  |   |  |   |  |   |  |   |  |
| ACTUAL SIGNATURE<br><i>Thomas D. Smith</i>   |         |  |  | TITLE (SPECIFY)<br>Deputy Chief   |  |   |  | DATE SIGNED<br>12/5/79  |  |   |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT)   |         |  |  | ADDRESS   |  |   |  |   |  |   |  |
| Thomas D. Smith, M.D.  |         |  |  | 111 Penn Street, Balto, MD. 21201   |  |   |  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)   |         | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY  |  |   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE  |  |   |  |
| Burial   |         | 12/8/1979  |  | Md. Nat. Mem. Park  |  |   |  | Laurel, Maryland  |  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS   |         |  |  |   |  | 25a. DATE REC'D. BY REGISTRAR   |  | 25b. REGISTRAR'S SIGNATURE  |  |   |  |
| Wm. C. March F/H 1101 East North Avenue  |         |  |  |   |  | DEC 6 1979  |  | <i>Robert H. Hickey</i>   |  |   |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  |  |  |   |  |                            |  |                     |  |   |  |   |  |
|---|--|---|--|--|--|---|--|----------------------------|--|---------------------|--|---|--|---|--|
| 1. FOR<br>STATE<br>REGISTRAR  |  | 2a. DATE OF DEATH   |  |  |  | MONTH   |  | DAY                        |  | YEAR                |  | 2b. HOUR  |  | P   |  |
| I. DECEASED NAME<br>(TYPE OR PRINT)   |  | FIRST   |  | MIDDLE   |  | LAST  |  | DECEMBER 31                |  | 1979                |  | 6:10  |  | M   |  |
| MERLE B. SMITH  |  |   |  |  |  |   |  |                            |  |                     |  |   |  |   |  |
| 3 SEX   |  | 4 RACE  |  | 5 DATE OF BIRTH  |  | 6 AGE (IN YEARS LAST BIRTHDAY)                                      |  | 7 IF UNDER 1 YEAR          |  | 8 IF UNDER 24 HRS   |  |   |  |   |  |
| Male  |  | White   |  | June 13 1915   |  | 64  |  | YRS.                       |  | MONTHS              |  | DAYS  |  | HOURS   |  |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  | 7b CITIZEN OF WHAT COUNTRY?   |  | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH                                 |  |                            |  |                     |  |   |  |   |  |
| Penna.  |  | U S A   |  |  |  | BALTIMORE CITY MD.  |  |                            |  |                     |  |   |  |   |  |
| 10 CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |  |  |   |  |                            |  |                     |  | 12a USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE) |  | 12b. KIND OF BUSINESS OR INDUSTRY               |  |
| Baltimore   |  | THE JOHNS HOPKINS HOSPITAL  |  |  |  |   |  |                            |  |                     |  | Machinist   |  | Railroad  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  | 13a STATE   |  | 13b COUNTY   |  | 13c CITY OR TOWN  |  | 13d. INSIDE CITY LIMITS?   |  | 13e. STREET ADDRESS |  |   |  |   |  |
| Penna.  |  | Franklin  |  | Chambersburg   |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |                            |  | 654 Stouffer Ave.   |  |   |  |   |  |
| 14 FATHER'S NAME  |  | 15. MOTHER'S MAIDEN NAME  |  |  |  |   |  |                            |  |                     |  |   |  |   |  |
| FIRST MIDDLE LAST   |  | FIRST MIDDLE LAST   |  |  |  |   |  |                            |  |                     |  |   |  |   |  |
| Howard L. Smith   |  | Mary E. Bitner  |  |  |  |   |  |                            |  |                     |  |   |  |   |  |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)   |  | 16b SOCIAL SECURITY NO  |  | 17 INFORMANT   |  | ADDRESS   |  |                            |  |                     |  |   |  |   |  |
| No  |  | 717-09-8188   |  | Blanche B. Smith   |  | Chambersburg, Pa. 17201   |  |                            |  |                     |  |   |  |   |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY  |  |   |  |  |  |   |  |                            |  |                     |  |   |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |  |
| IMMEDIATE CAUSE (a) <u>infection, g.i. bleeding</u>   |  |   |  |  |  |   |  |                            |  |                     |  |   |  | 3-4 wks   |  |
| DUE TO, OR AS A CONSEQUENCE OF (b) <u>bone marrow failure</u>   |  |   |  |  |  |   |  |                            |  |                     |  |   |  | 6 wks   |  |
| DUE TO, OR AS A CONSEQUENCE OF (c) <u>multiple myeloma</u>  |  |   |  |  |  |   |  |                            |  |                     |  |   |  | 3 years   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |   |  |  |  |   |  |                            |  |                     |  |   |  |   |  |
| 19a DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?      |  |                            |  |                     |  |   |  |   |  |
| none  |  |   |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | YES <input type="checkbox"/> NO <input type="checkbox"/>            |  |                            |  |                     |  |   |  |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |   |  |                            |  |                     |  |   |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC)                                     |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |   |  |                            |  |                     |  |   |  |   |  |
|   |  |   |  |  |  |   |  |                            |  |                     |  |   |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>Dec 1</u> 19 <u>79</u> to <u>Dec 31</u> 19 <u>79</u> , that (I) (we) lost<br>saw the deceased alive on <u>Dec 31</u> 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death. |  |   |  |  |  |   |  |                            |  |                     |  |   |  |   |  |
| 22b. SIGNATURE  |  | DEGREE  |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>                 |  | 22c. DATE SIGNED  |  |                            |  |                     |  |   |  |   |  |
| <u>Karen Hamilton</u>   |  | MD  |  |  |  | 12/31/79  |  |                            |  |                     |  |   |  |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  | 22e. ADDRESS  |  |  |  |   |  |                            |  |                     |  |   |  |   |  |
| Karen Hamilton  |  | Johns Hopkins Hospital  |  |  |  |   |  |                            |  |                     |  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)  |  | 23b. DATE   |  | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION<br>CITY OR TOWN                                       |  | COUNTY                     |  | STATE               |  |   |  |   |  |
| Burial  |  | 1-5-1980  |  | Lincoln Cemetery   |  | Chambersburg  |  | Franklin                   |  | Pa.                 |  |   |  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME  |  | 152 S. 2nd St, Chambersburg   |  | Pa. 17201  |  | 25a. DATE REC'D. BY REGISTRAR                                       |  | 25b. REGISTRAR'S SIGNATURE |  |                     |  |   |  |   |  |
| John Park   |  |   |  |  |  | JAN 4 1980  |  | <u>John A. Crosby</u>      |  |                     |  |   |  |   |  |







TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death, and retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  |  |  |  |  |  |  |
|--|--|--|--|--|--|--|--|--|--|
| 1. FOR STATE REGISTRAR   |  | 7 9 3 0 6 4 2<br>REG. NO.  |  | 1 DECEASED NAME (TYPE OR PRINT)<br>Nellie Marie Smith  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br>12-15-79   |  | 2b. HOUR<br>7:00A.M.                             |  |
| 3. SEX<br>F  |  | 4 RACE<br>Negro  |  | 5 DATE OF BIRTH MONTH DAY YEAR<br>JUNE 23, 1934  |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br>45 YRS.  |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN         |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>SUSSEX CO., VA.   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD.  |  |  |  |
| 10 CITY OR TOWN OF DEATH<br>BALTIMORE  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>ST. AGNES HOSPITAL |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>N/A   |  | 12b. KIND OF BUSINESS OR INDUSTRY                |  |
| 13a. STATE<br>MARYLAND   |  | 13b. COUNTY<br>N/A   |  | 13c. CITY OR TOWN<br>BALTIMORE   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |  | 13e. STREET ADDRESS<br>742 SOUTH WOODINGTON ROAD |  |
| 14 FATHER'S NAME FIRST MIDDLE LAST<br>JAMES MELTON   |  |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST   |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>N/A   |  | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)<br>N/A  |  | 17. INFORMANT<br>MR. JAMES SMITH   |  | ADDRESS<br>742 SOUTH WOODINGTON ROAD   |  |  |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) UREMIA<br>1809 } DUE TO, OR AS A CONSEQUENCE OF CERVICAL CARCINOMA<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO, OR AS A CONSEQUENCE OF OF THE UTERUS.<br>(c) |  |  |  |  |  |  |  |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)   |  |  |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)   |  |  |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                                |  |  |  |  |  |  |  |  |  |
| 22b. SIGNATURE<br>Chang Min Boo  |  |  |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>       |  | 22c. DATE SIGNED<br>12-15-79   |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>CHANG MIN BOO   |  |  |  | 22e. ADDRESS<br>ST. AGNES HOSPITAL   |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>BURIAL  |  | 23b. DATE<br>12-19-79  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>ARBUTUS MEM. PK.   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br>ARBUTUS, MD.  |  |  |  |
| 24 FUNERAL DIRECTOR NAME<br>LEROY O. DYETT & SON FUN. HOME   |  |  |  | ADDRESS<br>4600 LIB. HGT. AV.  |  | 25a. DATE REC'D. BY REGISTRAR<br>DEC 18 1979   |  | 25b. REGISTRAR'S SIGNATURE<br>Anthony McCreedy   |  |

STED 10-17-70

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DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

79 30643

1. FOR  
STATE  
REGISTRAR

|   |  |   |   |  |   |  |  |  |  |  |
|---|--|---|---|--|---|--|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Ralph (NMN) Smith</b>  |  |   | 2a. DATE OF DEATH<br>MONTH <b>12</b> DAY <b>26</b> YEAR <b>79</b>                   |  |   | 2b. HOUR<br><b>1250 A.M.</b>   |  |  |  |  |
| 3 SEX<br><b>Male</b>  |  | 4 RACE<br><b>White</b>  |   | 5. DATE OF BIRTH<br>MONTH <b>07</b> DAY <b>04</b> YEAR <b>05</b>   |   | 6 AGE (IN YEARS LAST BIRTHDAY)<br><b>74</b> YRS                                      |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.   |  |  |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>W. Va.</b>   |  | 7b CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |   | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><b>Balt. City</b> MD.                         |  |  |  |  |
| 10 CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>So. Balt. Gen. Hosp</b> |   |  |   | 12a USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Ret. Guard</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Security</b>   |  |  |
| 13a STATE<br><b>MD</b>  |  |   | 13b COUNTY<br><b>Baltimore</b>  |  | 13c CITY OR TOWN<br><b>Baltimore</b>  |  | 13d INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e STREET ADDRESS<br><b>4914 Brookwood Rd</b> |  |
| 14 FATHER'S NAME<br>FIRST <b>Silas</b> MIDDLE <b>--</b> LAST <b>Smith</b>   |  |   | 15 MOTHER'S MAIDEN NAME<br>FIRST <b>Lillie</b> MIDDLE <b>J.</b> LAST <b>Bovered</b> |  |   |  |  |  |  |  |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>Yes W.W. 2</b>  |  |   | 16b SOCIAL SECURITY NO.<br><b>236-16-6799</b>                                       |  | 17 INFORMANT<br><b>Letha B. Smith</b>   |  | 4914 Brookwood Road<br>Balto., Md. 21225   |  |  |  |
| 18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>RESP. INSUFFICIENCY -</b><br><b>496 -</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>b) <b>COPD -</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>c) <b>DUE TO, OR AS A CONSEQUENCE OF</b> |  |   |   |  |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):  |  |   |   |  |   |  |  |  |  |  |
| 19a. DATE OF OPERATION  |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                    |  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                          |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)              |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>12/14/79</b> , 19 <b>79</b> , to <b>12/26</b> , 19 <b>79</b> , that (I) (we) last saw the deceased alive on <b>12/26</b> , 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.      |  |   |   |  |   |  |  |  |  |  |
| 22b. SIGNATURE<br><b>David M Phelps</b>   |  |   |   |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br><b>12/26/79</b>  |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>DAVID M PHELPS</b>  |  |   |   |  | 22e. ADDRESS<br><b>So. Balt. Gen. Hosp</b>  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>  |  |   | 23b. DATE<br><b>Dec. 29, 1979</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Bealls Mill Cemetery</b>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Gassaway West Virginia</b>                    |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME <b>McCully Funeral Home of Brooklyn Baltimore, Md.</b> ADDRESS <b>237 East Patapsco Avenue</b>   |  |   |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>DEC 28 1979</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>Robert McPherson</b>  |  |  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 of 2 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



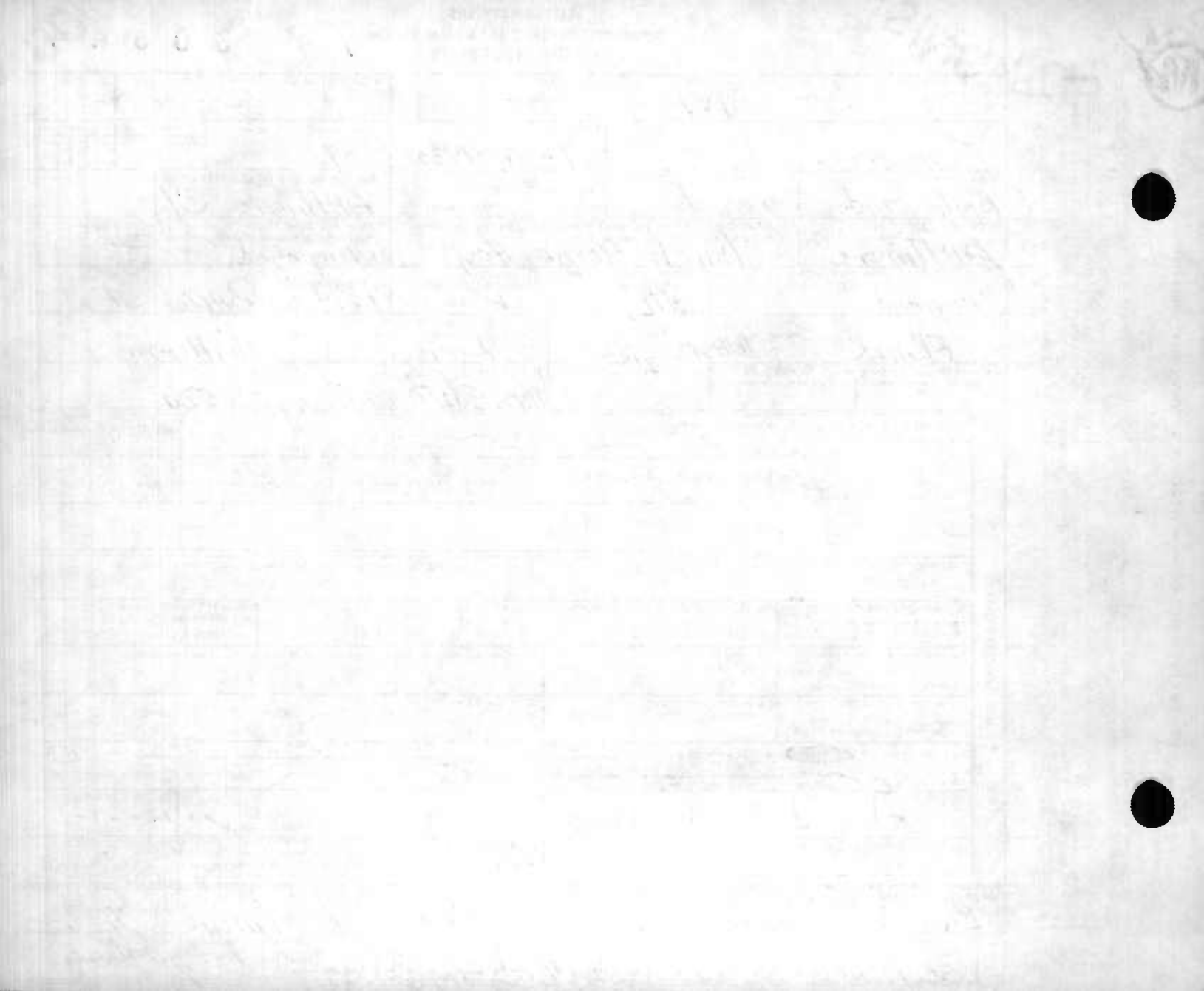
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  |  |  |  |  |   |  | 79 30644<br>REG. NO.                                 |  |  |  |
|--|--|--|--|--|--|--|--|---|--|--|--|--|--|
| 1- FOR STATE REGISTRAR   |  | 1 DECEASED NAME<br>(TYPE OR PRINT) REVA DELORES SMITH  |  |  |  | 2a DATE OF DEATH<br>MONTH DAY YEAR 12-21-79  |  |   |  | 2b HOUR<br>7:00pm                                    |  |  |  |
| 3 SEX<br>Female  |  | 4 RACE<br>Col.   |  | 5 DATE OF BIRTH<br>MONTH DAY YEAR 1-18-1932  |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br>37 YRS.  |  | 7 UNDER 1 YEAR<br>MONTHS DAYS   |  | 7 UNDER 74 HRS<br>HOURS MIN.                         |  |  |  |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Baltimore, Md.   |  | 7b CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD.                                      |  |   |  |  |  |  |  |
| 10 CITY OR TOWN OF DEATH<br>BALTIMORE  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Church Home Hosp. |  |  |  | 12a USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Unemployed                  |  | 12b KIND OF BUSINESS OR INDUSTRY  |  |  |  |  |  |
| 13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13b STATE<br>Maryland   |  | 13b COUNTY   |  | 13c CITY OR TOWN<br>Baltimore  |  | 13d INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e STREET ADDRESS<br>1814 W. BALTO. ST.  |  |  |  |  |  |
| 14 FATHER'S NAME<br>FRANK  |  | MIDDLE<br>WASHINGTON   |  | LAST   |  | 15 MOTHER'S MAIDEN NAME<br>FIRST<br>Louise   |  | MIDDLE<br>Williams  |  | LAST   |  |  |  |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)  |  | 16b SOCIAL SECURITY NO   |  | 17 INFORMANT<br>Mrs. Edith Anthony   |  |  |  | ADDRESS<br>1005 DU  |  |  |  |  |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY: <b>xx ASPIRATION PNEUMONIA</b><br>IMMEDIATE CAUSE (a):<br>3489 DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last }<br>BRAIN DAMAGE FROM CARDIAC ARREST IN PAST YEARS<br>DUE TO, OR AS A CONSEQUENCE OF (c): |  |  |  |  |  |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>DAYS |  |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)  |  |  |  |  |  |  |  |   |  |  |  |  |  |
| 19a DATE OF OPERATION<br>12-5-79<br>XXXXXXXXXX   |  | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED<br>GASTROSTOMY   |  |  |  | 20a AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                       |  | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |  |  |  |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |   |  |  |  |  |  |
| 21d INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f LOCATION<br>STREET   |  | CITY OR TOWN   |  | COUNTY  |  | STATE  |  |  |  |
| 22a I certify that (1) this hospital attended the deceased from 12-21-79 to 12-21-79, 1979, that (1) we first saw the deceased on 12-21-79, 1979, and that in (my) opinion death occurred on the date and hour and from the causes stated above, (1) we did (not) view the body after death.   |  |  |  |  |  |  |  |   |  |  |  |  |  |
| 22b SIGNATURE<br>A. J. Helou, M.D.   |  | DEGREE   |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                 |  |  |  | 22c DATE SIGNED<br>12-21-79   |  |  |  |  |  |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT)<br>DR. A. J. HELOU  |  |  |  | 22e ADDRESS<br>CHURCH HOSPITAL CORPORATION<br>100 N. BROADWAY BALTIMORE, MARYLAND 31   |  |  |  |   |  |  |  |  |  |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial   |  | 23b DATE<br>12-28-79   |  | 23c NAME OF CEMETERY OR CREMATORY<br>Mt. Zion Cem  |  | 23d LOCATION<br>CITY OR TOWN<br>BALTIMORE  |  | COUNTY<br>Md.   |  | STATE  |  |  |  |
| 24 FUNERAL DIRECTOR<br>NAME<br>Joseph L. Russ  |  |  |  | ADDRESS<br>2222 W. North Ave.  |  | 25a DATE REC'D. BY REGISTRAR<br>JAN 7 1980   |  | 25b REGISTRAR'S SIGNATURE<br>[Signature]  |  |  |  |  |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  | 7 9 3 0 6 4 5<br>REG. NO.   |  |   |  |
|---|--|--|--|---|--|---|--|
| 1- FOR STATE REGISTRAR  |  |  |  |   |  |   |  |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br>STANLEY L. SMITH, III   |  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br>12/17/79  |  | 2b. HOUR<br>7 <sup>20</sup> AM  |  |
| 3 SEX<br>Male   |  | 4 RACE<br>Black  |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>7 15 22  |  | 6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS<br>57 YRS.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Md. (VA)   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>CITY MD.  |  |
| 10. CITY OR TOWN OF DEATH<br>BALT   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Univ Md University Hosp. |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>N/A  |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |
| 13a. STATE<br>MD  |  |  |  | 13b. COUNTY<br>BALT   |  | 13c. CITY OR TOWN<br>BALT   |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>N/A Stanley Smith, Jr.   |  |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>(Lillian) Lillie Foote  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)   |  | 16b. SOCIAL SECURITY NO.<br>216-18-0776  |  | 17. INFORMANT ADDRESS<br>CHART 2706 Mosher Street   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) 1509 CARDIO RESPIRATORY ARREST<br>DUE TO, OR AS A CONSEQUENCE OF (b) AIRWAY OBSTRUCTION TRACHEA;<br>DUE TO, OR AS A CONSEQUENCE OF (c) METASTATIC ESOPHAGEAL CA<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |  |  |   |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |  |  |   |  |   |  |
| 19a. DATE OF OPERATION<br>11/1/79   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br>SUPPORT  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 10/15/79 to 12/17/79, that (I) (we) lost saw the deceased alive on 12/17/79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.  |  |  |  |   |  |   |  |
| 22b. SIGNATURE<br>W. C. Moore   |  |  |  | DEGREE<br>107   |  | 22c. DATE SIGNED<br>12/17/79  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>MOORE  |  |  |  | 22e. ADDRESS<br>Univ Md 22 S Green St.  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial   |  | 23b. DATE<br>12/21/1979  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Mt. Auburn Cemetery   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br>Baltimore, Maryland  |  |
| 24. FUNERAL DIRECTOR NAME<br>Wm. C. March F/H 1101 East North Avenue  |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br>DEC 18 1979  |  | 25b. REGISTRAR'S SIGNATURE<br>P. J. Kelly   |  |

CHODS 11

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2

(2)

COLL 1 FEB

CHODS



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. GIVE PAGE 4 TO THE CHIEF MEDICAL EXAMINER ALONG WITH YOUR FILES. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP  
DHMM - 17  
(VR A15 ME (5))  
30M 7/73

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

30646

1. FOR  
STATE  
REGISTRAR

|  |  |         |  |   |  |                   |  |  |  |   |  |   |  |       |  |  |  |   |  |                          |  |                     |  |
|--|--|---------|--|---|--|-------------------|--|--|--|---|--|---|--|-------|--|--|--|---|--|--------------------------|--|---------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  | FIRST   |  | MIDDLE  |  | LAST              |  | 2a. DATE KNOWN OF DEATH  |  | <input checked="" type="checkbox"/> MONTH |  | DAY   |  | YEAR  |  | 2b. HOUR                                     |  |   |  |                          |  |                     |  |
| TREVOR   |  |         |  |   |  | AVALON SMITH      |  | 12   |  | 9   |  | 19  |  | 79    |  | M  |  |   |  |                          |  |                     |  |
| 3. SEX   |  | 4. RACE |  | 5. DATE OF BIRTH  |  | 6. AGE (IN YEARS) |  | IF UNDER 1 YR.   |  | IF UNDER 24 HRS.                          |  | 7c. DATE PRONOUNCED DEAD  |  | MONTH |  | DAY  |  | YEAR  |  | 2d. HOUR                 |  |                     |  |
| male   |  | negro   |  | 7-7-35  |  | 47 YRS.           |  |  |  |   |  | 12  |  | 9     |  | 19   |  | 79  |  | 9:20 p M                 |  |                     |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  |         |  | 7b. CITIZEN OF WHAT COUNTRY?  |  |                   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |   |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |  |       |  |  |  |   |  |                          |  |                     |  |
| Jamaica  |  |         |  | Kingston, Jamaica   |  |                   |  |  |  |   |  | Baltimore City MD.  |  |       |  |  |  |   |  |                          |  |                     |  |
| 10. CITY OR TOWN OF DEATH  |  |         |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |                   |  |  |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)       |  |       |  | 12b. KIND OF BUSINESS OR INDUSTRY            |  |   |  |                          |  |                     |  |
| Baltimore  |  |         |  | 1901 Eutaw Place  |  |                   |  |  |  |   |  |   |  |       |  |  |  |   |  |                          |  |                     |  |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |         |  |   |  |                   |  | 13a. STATE   |  |   |  |   |  |       |  | 13b. COUNTY                                  |  | 13c. CITY OR TOWN   |  | 13d. INSIDE CITY LIMITS? |  | 13e. STREET ADDRESS |  |
|  |  |         |  |   |  |                   |  | Md.  |  | BALTO.                                    |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |       |  | 1901 EUTAW PL. APT 3A                        |  |   |  |                          |  |                     |  |
| 14. FATHER'S NAME  |  |         |  | 15. MOTHER'S MAIDEN NAME  |  |                   |  |  |  |   |  |   |  |       |  |  |  |   |  |                          |  |                     |  |
| FIRST  |  |         |  | MIDDLE  |  |                   |  | LAST   |  |   |  | FIRST   |  |       |  | MIDDLE                                       |  |   |  | LAST                     |  |                     |  |
| Oswald   |  |         |  | Avalon  |  |                   |  |  |  |   |  | ESTELLE Waite   |  |       |  |  |  |   |  |                          |  |                     |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)   |  |         |  | 16b. SOCIAL SECURITY NO.  |  |                   |  | 17. INFORMANT ADDRESS  |  |   |  |   |  |       |  |  |  |   |  |                          |  |                     |  |
| NO   |  |         |  |   |  |                   |  | JOAN PATTERSON 5615 Haddon Ave.  |  |   |  |   |  |       |  |  |  |   |  |                          |  |                     |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |  |         |  |   |  |                   |  |  |  |   |  |   |  |       |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |   |  |                          |  |                     |  |
| PART I DEATH WAS CAUSED BY: 9654 Gunshot wound of chest (unspecified weapon)   |  |         |  |   |  |                   |  |  |  |   |  |   |  |       |  |  |  |   |  |                          |  |                     |  |
| IMMEDIATE CAUSE (a)  |  |         |  |   |  |                   |  |  |  |   |  |   |  |       |  |  |  |   |  |                          |  |                     |  |
| DUE TO, OR AS A CONSEQUENCE OF   |  |         |  |   |  |                   |  |  |  |   |  |   |  |       |  |  |  |   |  |                          |  |                     |  |
| Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.  |  |         |  |   |  |                   |  |  |  |   |  |   |  |       |  |  |  |   |  |                          |  |                     |  |
| (b)  |  |         |  |   |  |                   |  |  |  |   |  |   |  |       |  |  |  |   |  |                          |  |                     |  |
| DUE TO, OR AS A CONSEQUENCE OF   |  |         |  |   |  |                   |  |  |  |   |  |   |  |       |  |  |  |   |  |                          |  |                     |  |
| (c)  |  |         |  |   |  |                   |  |  |  |   |  |   |  |       |  |  |  |   |  |                          |  |                     |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).  |  |         |  |   |  |                   |  |  |  |   |  |   |  |       |  |  |  |   |  |                          |  |                     |  |
| 19a. DATE OF OPERATION   |  |         |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |  |                   |  |  |  |   |  |   |  |       |  |  |  | 20. AUTOPSY?  |  |                          |  |                     |  |
|  |  |         |  |   |  |                   |  |  |  |   |  |   |  |       |  |  |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |                          |  |                     |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |  |         |  | 21b. TIME OF INJURY   |  |                   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)  |  |   |  |   |  |       |  |  |  |   |  |                          |  |                     |  |
|  |  |         |  | HOUR <del>XXX</del> MONTH DAY YEAR  |  |                   |  | Subject shot by assailant.   |  |   |  |   |  |       |  |  |  |   |  |                          |  |                     |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK   |  |         |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)   |  |                   |  | 21f. LOCATION  |  |   |  | CITY OR TOWN  |  |       |  | COUNTY                                       |  | STATE   |  |                          |  |                     |  |
|  |  |         |  | home  |  |                   |  | 1901 Eutaw Place, Balto.   |  |   |  |   |  |       |  | Md.  |  |   |  |                          |  |                     |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> |  |         |  |   |  |                   |  |  |  |   |  |   |  |       |  |  |  |   |  |                          |  |                     |  |
| ACTUAL SIGNATURE   |  |         |  | TITLE (SPECIFY)   |  |                   |  | DATE SIGNED  |  |   |  |   |  |       |  |  |  |   |  |                          |  |                     |  |
| Ann M. Dixon, M.D.   |  |         |  | M.D. Assistant  |  |                   |  | MEDICAL EXAMINER   |  |   |  | 12-10-79  |  |       |  |  |  |   |  |                          |  |                     |  |
| EXAMINER'S NAME (TYPE OR PRINT)  |  |         |  | ADDRESS   |  |                   |  |  |  |   |  |   |  |       |  |  |  |   |  |                          |  |                     |  |
| Ann M. Dixon, M.D.   |  |         |  | 111 Penn St.  |  |                   |  |  |  |   |  |   |  |       |  |  |  |   |  |                          |  |                     |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |  |         |  | 23b. DATE   |  |                   |  | 23c. NAME OF CEMETERY OR CREMATORY   |  |   |  | 23d. LOCATION   |  |       |  |  |  |   |  |                          |  |                     |  |
| Burial   |  |         |  | 12-15-79  |  |                   |  |  |  |   |  | Baltimore, Maryland   |  |       |  |  |  |   |  |                          |  |                     |  |
| 24. FUNERAL DIRECTOR NAME  |  |         |  | ADDRESS   |  |                   |  | 25a. DATE REC'D. BY REGISTRAR  |  |   |  | 25b. REGISTRAR'S SIGNATURE  |  |       |  |  |  |   |  |                          |  |                     |  |
| Vernon Bailey  |  |         |  | 1348 Calhoun St.  |  |                   |  | DEC 12 1979  |  |   |  | [Signature]   |  |       |  |  |  |   |  |                          |  |                     |  |

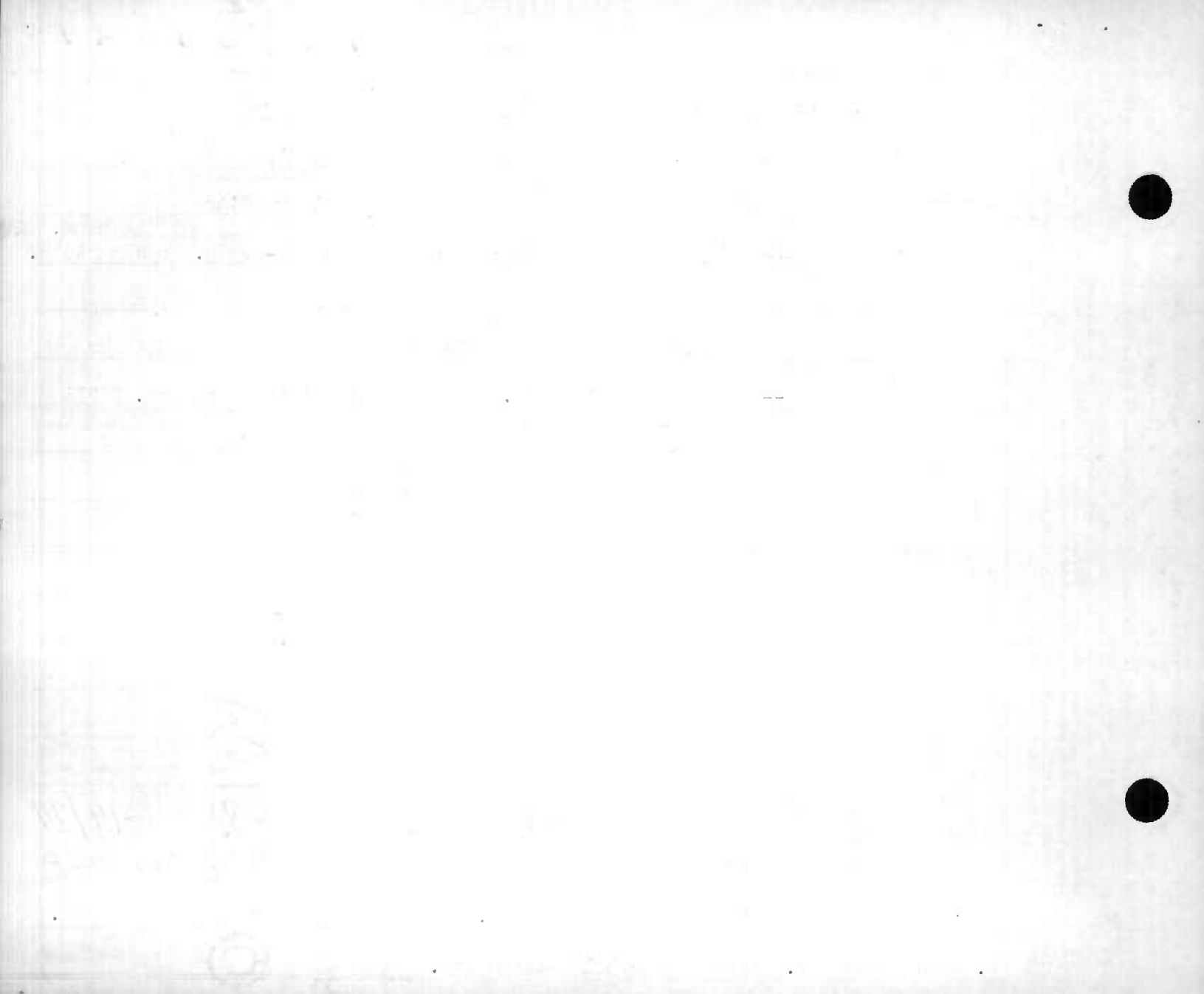


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |                              |   |   |  |  |                                      |  |   | 79 30647  |          |                 |  |
|--|--|------------------------------|---|---|--|--|--------------------------------------|--|---|---|----------|-----------------|--|
| FOR<br>STATE<br>REGISTRAR  |  |                              | REG. NO.  |   |  |  |                                      |  |   |   |          |                 |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  |                              | FIRST MIDDLE LAST   |   |  | 2a. DATE OF DEATH  |                                      |  | MONTH DAY YEAR  |   | 2b. HOUR |                 |  |
| William H. Smith   |  |                              |   |   |  | 12 9 79  |                                      |  |   |   | 2145 PM  |                 |  |
| 3. SEX   |  | 4. RACE                      |   | 5. DATE OF BIRTH  |  |  | 6. AGE (IN YEARS LAST BIRTHDAY)      |  |   | IF UNDER 1 YEAR                                 |          | IF UNDER 24 HRS |  |
| Male   |  | White                        |   | MONTH DAY YEAR<br>9 16 22   |  |  | 57 YRS.                              |  |   | MONTHS DAYS                                     |          | HOURS MIN.      |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  | 7b. CITIZEN OF WHAT COUNTRY? |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH |  |   |   |          |                 |  |
| Maryland   |  | USA                          |   |   |  |  | Baltimore City MD.                   |  |   |   |          |                 |  |
| 10. CITY OR TOWN OF DEATH  |  |                              | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)   |                                      |  | 12b. KIND OF BUSINESS OR INDUSTRY                                 |   |          |                 |  |
| Baltimore  |  |                              | Good Samaritan Hospital   |   |  | Housing Co-ordin.  |                                      |  | Housing Autho   |   |          |                 |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  |                              |   | 13a. INSIDE CITY LIMITS?  |  |  |                                      | 13b. STREET ADDRESS                                      |   |   |          |                 |  |
| 13a. STATE   |  |                              |   | 13b. COUNTY   |  |  |                                      | 13c. CITY OR TOWN  |   |   |          |                 |  |
| MD   |  |                              |   | Baltimore   |  |  |                                      | YES <input type="checkbox"/> NO <input type="checkbox"/> |   |   |          |                 |  |
| 14. FATHER'S NAME  |  |                              |   | 15. MOTHER'S MAIDEN NAME  |  |  |                                      |  |   |   |          |                 |  |
| FIRST MIDDLE LAST  |  |                              |   | FIRST MIDDLE LAST   |  |  |                                      |  |   |   |          |                 |  |
| John Smith   |  |                              |   | Alvina Creamer  |  |  |                                      |  |   |   |          |                 |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)   |  |                              |   | 16b. SOCIAL SECURITY NO.  |  |  |                                      | 17. INFORMANT ADDRESS                                    |   |   |          |                 |  |
| No   |  |                              |   | 215-14-4562   |  |  |                                      | Mrs. Shirley Smith 3732 Beech Ave. 21211                 |   |   |          |                 |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Septic Shock</u><br><u>1629</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Cedena Co of lung</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>Brain metastases</u>   |  |                              |   |   |  |  |                                      |  |   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |          |                 |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |                              |   |   |  |  |                                      |  |   |   |          |                 |  |
| 19a. DATE OF OPERATION   |  |                              | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   |  | 20a. AUTOPSY?  |                                      |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH? |   |          |                 |  |
|  |  |                              |   |   |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                                      |  | YES <input type="checkbox"/> NO <input type="checkbox"/>          |   |          |                 |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |                              | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |                                      |  |   |   |          |                 |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  |                              | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |                                      |  |   |   |          |                 |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>12/9</u> , 19 <u>79</u> , to <u>12/9</u> , 19 <u>79</u> , that (I) (we) lost<br>saw the deceased alive on <u>12/9</u> , 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death. |  |                              |   |   |  |  |                                      |  |   |   |          |                 |  |
| 22b. SIGNATURE   |  |                              | DEGREE  |   |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |                                      |  | 22c. DATE SIGNED  |   |          |                 |  |
| <u>Zaglama</u>   |  |                              | MD  |   |  |  |                                      |  | 12/9/79   |   |          |                 |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  |                              | 22e. ADDRESS  |   |  |  |                                      |  |   |   |          |                 |  |
| NABIL ZAGLAMA  |  |                              | The Good Samaritan Hosp.  |   |  |  |                                      |  |   |   |          |                 |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)   |  |                              | 23b. DATE   |   |  | 23c. NAME OF CEMETERY OR CREMATORY   |                                      |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE                        |   |          |                 |  |
| Burial   |  |                              | 12/13/79  |   |  | Moreland Mem. Park   |                                      |  | Baltimore Md.   |   |          |                 |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS   |  |                              |   |   |  | 25a. DATE REC'D. BY REGISTRAR  |                                      |  | 25b. REGISTRAR'S SIGNATURE  |   |          |                 |  |
| A. Alan Seitz, Jr. Funeral Home 3818 Roland Ave.   |  |                              |   |   |  | DEC 14 1979  |                                      |  | <u>Anthony McBrady</u>  |   |          |                 |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  |   |  |  |                                       |   |  |  |
|---|--|---|--|---|--|--|---------------------------------------|---|--|--|
| 1. FOR STATE REGISTRAR  |  |   |  |   | REG. NO. 79 30648  |  |                                       |   |  |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>JOHN F SNEED JR</b>   |  |   |  |   | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>12 3 29</b>                   |  |                                       | 2b. HOUR<br><b>1 P</b> M  |  |  |
| 3. SEX<br><b>male</b>   |  | 4. RACE<br><b>white</b>   |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>12 20 1920</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>58</b> YRS                                     |                                       | 7. IF UNDER 1 YEAR MONTHS DAYS<br>IF UNDER 24 HRS HOURS MIN.  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Cereysville, Tenn</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City MD</b>                     |                                       |   |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Baltimore City Hospitals</b> |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Truck Driver</b> |                                       | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Durrett Shepar</b>  |  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE<br><b>Maryland</b>   |  |   |  |   | 13b. COUNTY<br><b>Baltimore</b>                                      |  | 13c. CITY OR TOWN<br><b>Baltimore</b> |   | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>John F. Sneed</b>   |  |   |  |   | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>Stella Campbell</b> |  |                                       |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br><b>yes</b>   |  | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)<br><b>220 18 3478</b>  |  | 17. INFORMANT ADDRESS<br><b>Betty Wilson 2423 E. Fayette Street 21224</b>   |  |  |                                       |   |  |  |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiopulmonary arrest</b><br><b>1629</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>metastatic lung cancer</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>12 mos</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |   |  |   |  |  |                                       | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>3 minutes</b>  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |   |  |   |  |  |                                       |   |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>               |                                       | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><b>19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2)  |  |  |                                       |   |  |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |  |                                       |   |  |  |
| 22a. I certify that (I) <u>the hospital</u> attended the deceased from <u>July</u> , 19 <u>79</u> , to <u>Dec 3</u> , 19 <u>79</u> , that (I) <u>lost</u> saw the deceased alive on <u>Dec 3</u> , 19 <u>79</u> , and that in (my) <u>opinion</u> death occurred on the date and hour and from the causes stated above. (I) <u>did not</u> view the body after death.                                 |  |   |  |   |  |  |                                       |   |  |  |
| 22b. SIGNATURE<br><b>Richard Barnett MD</b>   |  | 22c. DATE SIGNED<br><b>12/3/79</b>  |  |   |  |  |                                       | 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Richard Barnett</b>   |  |  |
| 22e. ADDRESS<br><b>Dept of Medicine, Balt. City Hosp</b>  |  | 22f. DATE RECEIVED BY REGISTRAR<br><b>DEC 5 1979</b>  |  |   |  |  |                                       |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>12/6/79</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Oak Lawn Cemetery</b>  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><b>Baltimore Md</b>                       |                                       | 23e. REGISTRAR'S SIGNATURE<br><b>Richard Barnett</b>  |  |  |
| 24. FUNERAL DIRECTOR NAME<br><b>Walter Dabrowski</b>  |  | 24b. ADDRESS<br><b>1005 Dundalk Avenue</b>  |  |   |  |  |                                       |   |  |  |

12/10/79

F

JOHN

12 10 1979

white

male

USA

Greenville, Tenn

Baltimore City Hospitals

Baltimore

Baltimore

Maryland

Scalia

John F. Speed

120 10 1979 Betty Wilson 2017 E. Apple Street 1124

yes

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  |  |  |  |   |  |  | REG. NO. 79 30649   |  |   |  |                                |  |
|--|--|--|--|--|--|--|---|--|--|---|--|---|--|--------------------------------|--|
| 1. FOR STATE REGISTRAR   |  |  |  |  |  |  |   |  |  | 2a. DATE OF DEATH   |  |   |  | 2b. HOUR                       |  |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br><b>Joseph E. Sniadach</b>  |  |  |  |  |  |  |   |  |  | MONTH DAY YEAR<br><b>12 26 79</b>   |  |   |  | 10:55 AM                       |  |
| 3 SEX<br><b>Male</b>   |  |  | 4 RACE<br><b>Cauc.</b>   |  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>7 14 29</b>   |   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>50</b>   |   |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br><b>YRS.</b>             |  | IF UNDER 24 HRS.<br>HOURS MIN. |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>   |  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  |  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |   |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><b>City</b> MD.   |   |  |   |  |                                |  |
| 10 CITY OR TOWN OF DEATH<br><b>Baltimore</b>   |  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Baltimore City</b> |  |  |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Press Operator</b>                                  |   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Western Elec.</b> |  |                                |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE 13b. COUNTY 13c. CITY OR TOWN<br><b>Maryland Baltimore</b>   |  |  |  |  |  |  |   |  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>6748 Roberts Avenue #22</b>     |  |                                |  |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Ignatius Sniadach</b>  |  |  |  |  |  | 15 MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Anna Kutz</b>   |   |  |  |   |  |   |  |                                |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>  |  |  | 16b. SOCIAL SECURITY NO.<br><b>214-26-3738</b>   |  |  | 17 INFORMANT<br><b>Edward Sniadach</b>   |   |  | ADDRESS<br><b>7505 Durwood Road<br/>Baltimore, Md, 21222</b>   |   |  |   |  |                                |  |
| 18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiac Arrest</b><br><b>5712</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>G-I Bleed</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Alcoholic Liver Cirrhosis</b> |  |  |  |  |  |  |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |   |  |                                |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><b>Pneumonia</b>   |  |  |  |  |  |  |   |  |  |   |  |   |  |                                |  |
| 19a. DATE OF OPERATION   |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |  |   |  |                                |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |   |  |  |   |  |   |  |                                |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |   |  |  |   |  |   |  |                                |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>12/17</b> , 19 <b>79</b> , to <b>12/26</b> , 19 <b>79</b> , that (I) (we) last saw the deceased alive on <b>12/26</b> , 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                                    |  |  |  |  |  |  |   |  |  |   |  |   |  |                                |  |
| 22b. SIGNATURE<br><b>Arnold Falchhook</b>  |  |  |  |  |  | DEGREE<br><b>M.D.</b>  |   |  | 22c. DATE SIGNED<br><b>12/26/79</b>  |   |  |   |  |                                |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>ARNOLD FALCHHOOK</b>   |  |  |  |  |  | 22e. ADDRESS<br><b>Balt. City. Hospital</b>  |   |  |  |   |  |   |  |                                |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |  |  | 23b. DATE<br><b>12/29/79</b>   |  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Holy Rosary</b>   |   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore</b>   |   |  |   |  |                                |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Walter Dabrowski - 1005 Dundalk Avenue #24</b>  |  |  |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>DEC 28 1979</b>  |   |  | 25b. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>   |   |  |   |  |                                |  |





|           |                      |   |    |    |    |
|-----------|----------------------|---|----|----|----|
| Male      | 1900                 | 7 | 14 | 29 | 50 |
| Maryland  | U.S.A.               |   |    |    |    |
| Baltimore | Baltimore City       |   |    |    |    |
| Maryland  | Baltimore            |   |    |    |    |
| Ignatius  | Sniedach             |   |    |    |    |
|           | Anna                 |   |    |    |    |
|           | 7503 Durwood Road    |   |    |    |    |
|           | Baltimore, Md. 21222 |   |    |    |    |
|           | Edward Sniedach      |   |    |    |    |
|           | 214-26-2738          |   |    |    |    |

Walter Dabrowski - 1005 Lombard Avenue  
12/10/79 Holy Rosary Baltimore



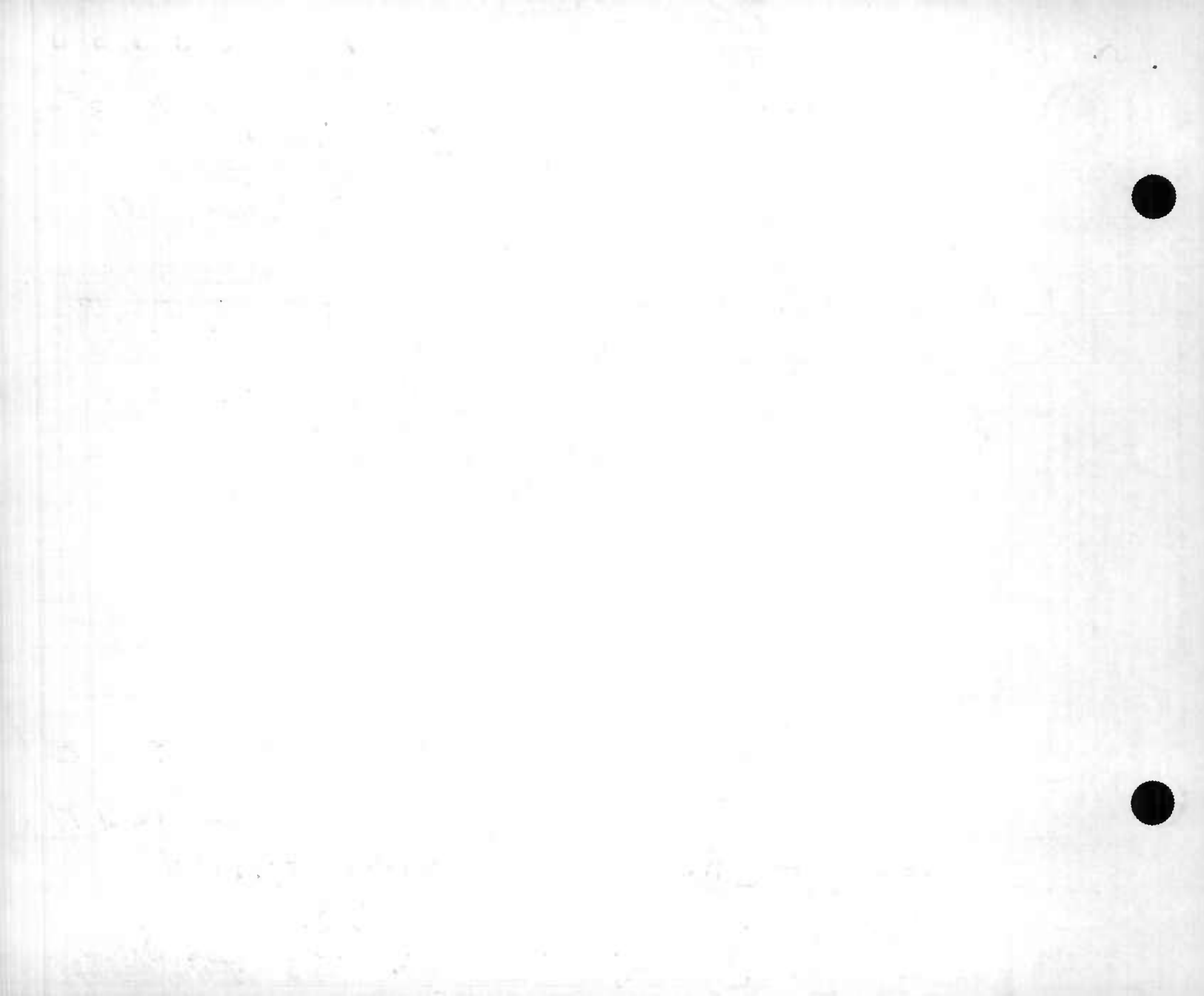
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  |  |  |  |   |   |  |  |
|---|--|---|--|--|--|--|---|---|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) <b>Isadore Snyder</b>  |  |   |  |  |  |  |   |   |  |  |
| 2a. DATE OF DEATH MONTH <b>12</b> DAY <b>21</b> YEAR <b>79</b>  |  |   |  |  |  |  |   |   |  |  |
| 2b. HOUR <b>3<sup>10</sup> P.M.</b>   |  |   |  |  |  |  |   |   |  |  |
| 3. SEX <b>M</b> <b>MALE</b>   |  |   | 4. RACE <b>W</b> <b>WHITE</b>  |  | 5. DATE OF BIRTH MONTH <b>AUG.</b> DAY <b>25</b> YEAR <b>1884</b>              |  | 6. AGE (IN YEARS LAST BIRTHDAY) <b>95</b> YRS.                    |   | 7. IF UNDER 1 YEAR MONTHS <b></b> DAYS <b></b> |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>RUSSIA</b>   |  | 7b. CITIZEN OF WHAT COUNTRY? <b>USA</b> |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.                 |   |   |  |  |
| 10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>  |  |   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Sinai Hospital</b> |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK OR PART OF WORKING LIFE) <b>TAILOR</b>     |   | 12b. KIND OF BUSINESS OR INDUSTRY <b>TAILORING</b>  |  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE <b>Maryland</b> 13c. COUNTY <b>Xxxxxxx</b> 13d. CITY OR TOWN <b>Baltimore</b> 13e. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> 13f. STREET ADDRESS <b>3107 Marnat Rd.</b>   |  |   |  |  |  |  |   |   |  |  |
| 14. FATHER'S NAME FIRST <b>ISAAC</b> MIDDLE <b></b> LAST <b>SNYDER</b>  |  |   |  |  | 15. MOTHER'S MAIDEN NAME FIRST <b>YETTA</b> MIDDLE <b></b> LAST <b>UNKNOWN</b> |  |   |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>   |  |   | 16b. SOCIAL SECURITY NO. <b>217-32-9941</b>  |  | 17. INFORMANT <b>MRS. HENRIETTA BLUMBERG</b> 3107 MARNAT RD. BALTO., MD 21208  |  |   |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Respiratory Arrest</b><br>4380 } DUE TO, OR AS A CONSEQUENCE OF (b) <b>Congestive Heart Failure</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } DUE TO, OR AS A CONSEQUENCE OF (c) <b></b><br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b></b> |  |   |  |  |  |  |   |   |  |  |
| 19a. DATE OF OPERATION  |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>         |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>  |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |   |   |  |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |   | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                 |   |   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>12-12</b> to <b>12-31</b> 19 <b>79</b> , that (I) <input checked="" type="checkbox"/> saw the deceased alive on <b>12-21</b> 19 <b>79</b> , and that in (my) <input checked="" type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.  |  |   |  |  |  |  |   |   |  |  |
| 22b. SIGNATURE <b>Vernon H. Ross</b> M.D.   |  |   |  |  | 22c. DATE SIGNED <b>12-21-79</b>   |  |   |   |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Vernon H. Ross</b>   |  |   |  |  | 22e. ADDRESS <b>Sinai Hospital</b>   |  |   |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>   |  |   | 23b. DATE <b>DEC. 23, 1979</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY <b>CHIZUK AMUNO</b>                         |  | 23d. LOCATION CITY OR TOWN COUNTY STATE <b>BALTIMORE MARYLAND</b> |   |  |  |
| 24. FUNERAL DIRECTOR NAME <b>SOL LEVINSON &amp; BROS., INC.</b> 6010 REISTERSTOWN RD. BALTO., MD 21215  |  |   |  |  | 25a. DATE REC'D. BY REGISTRAR <b>DEC 27 1979</b>                               |  | 25b. REGISTRAR'S SIGNATURE <b>P. J. Kelly</b>                     |   |  |  |





FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

7 9 3 0 6 5 1

REG. NO.

|   |  |  |  |   |   |  |  |  |   |   |                                 |  |
|---|--|--|--|---|---|--|--|--|---|---|---------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>BETTY  |  |  | FIRST MIDDLE LAST<br>SOSNER  |   |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>DEC. 15, 1979   |  |  | 2b. HOUR<br>11:45 PM                        |   |                                 |  |
| 3. SEX<br>FEMALE  |  | 4. RACE<br>WHITE   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>MAY 18, 1907  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>72 YRS.   |  |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS           |   | 8. IF UNDER 24 HRS<br>HOURS MIN |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>MARYLAND   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD.   |  |  |   |   |                                 |  |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>3705 CLARKS LANE APT. C (21215) |  |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>SECRETARY  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>J.C.C. |   |                                 |  |
| 13a. STATE<br>MARYLAND  |  | 13b. COUNTY  |  | 13c. CITY OR TOWN<br>BALTIMORE  |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 13e. STREET ADDRESS<br>3705 CLARKS LANE APT. C (21215)   |   |   |                                 |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>ABRAHAM WILLIAMS  |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>FANNIE TUROW   |   |  |  |  |   |   |                                 |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>NO  |  |  |  | 16b. SOCIAL SECURITY NO.  |   | 17. INFORMANT ADDRESS<br>APT. 201 (21209)<br>MRS. FLORA SMITH 6500 COOPER RIDGE DR.  |  |  |   |   |                                 |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Probable CVA</u><br>436-<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <u>Gen. Atherosclerosis</u><br>(c) <u>Gen. Atherosclerosis</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>DUE TO, OR AS A CONSEQUENCE OF |  |  |  |   |   |  |  |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>Minute</u> |                                 |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |  |  |   |   |  |  |  |   |   |                                 |  |
| 19a. DATE OF OPERATION  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |   |                                 |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |  |   |   |                                 |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |  |   |   |                                 |  |
| 22. I certify that (I) (this hospital) attended the deceased from <u>Aug 68</u> to <u>Nov. 15</u> , 19 <u>79</u> , that (I) (we) last saw the deceased alive on <u>Aug 79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.  |  |  |  |   |   |  |  |  |   |   |                                 |  |
| 22b. SIGNATURE<br><u>Daniel Bakal, MD</u>   |  |  |  |   |   | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br><u>12-16-79</u>  |   |   |                                 |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>DR. DANIEL BAKAL   |  |  |  |   |   | 22e. ADDRESS<br>600 REISTERSTOWN RD. (21208)   |  |  |   |   |                                 |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>BURIAL   |  |  | 23b. DATE<br>12/16/79  |   | 23c. NAME OF CEMETERY OR CREMATORY<br>BETH YEHUDA ANSHE KURLAND |  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>BALTIMORE MD.  |   |   |                                 |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>SOL LEVINSON & BROS 6010 REISTERSTOWN RD.<br>BALTO. MD. (21215)   |  |  |  |   |   | 25a. DATE REC'D. BY REGISTRAR<br>DEC 20 1979   |  | 25b. REGISTRAR'S SIGNATURE<br><u>Henry McBrady</u>   |   |   |                                 |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

10000

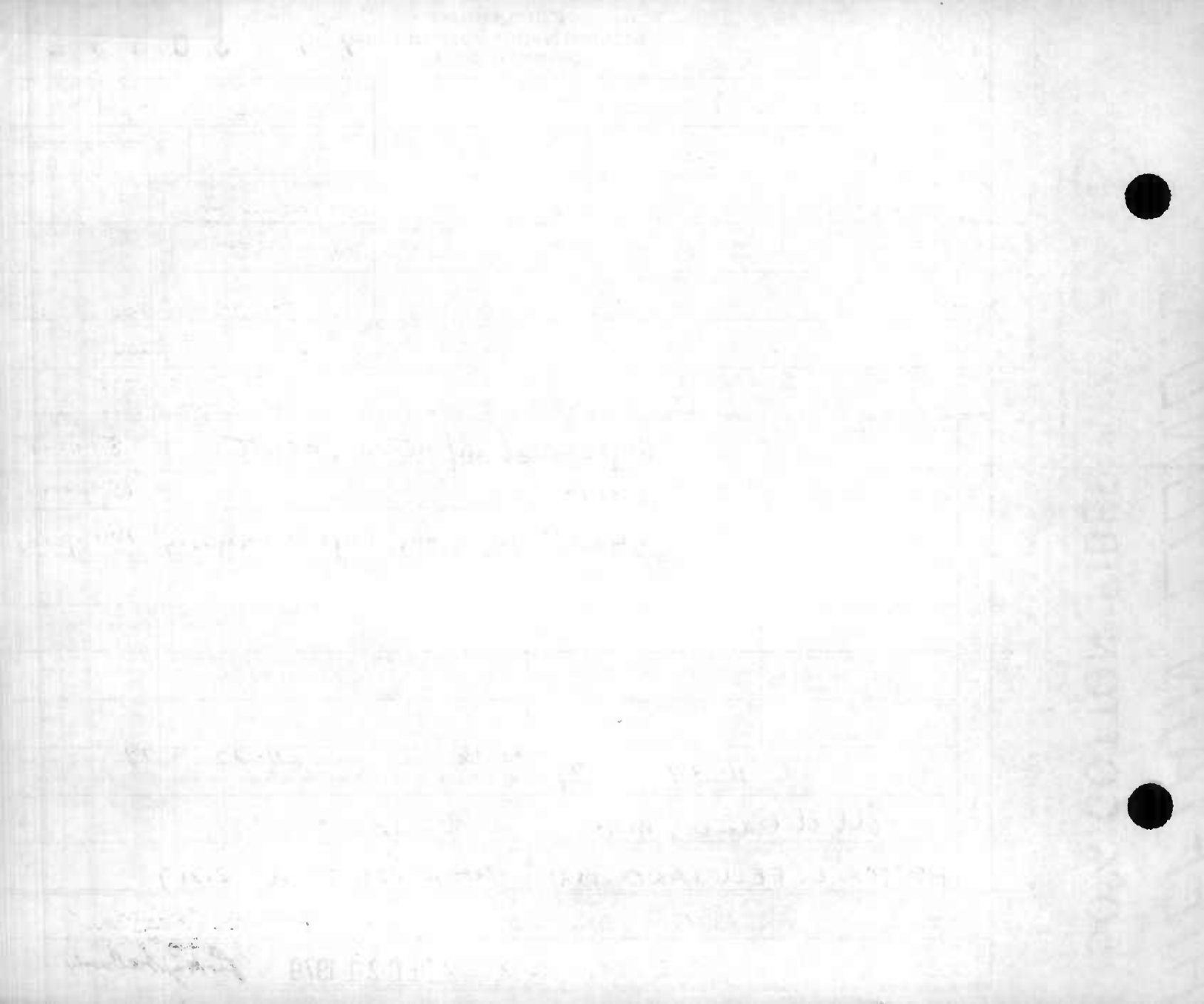


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

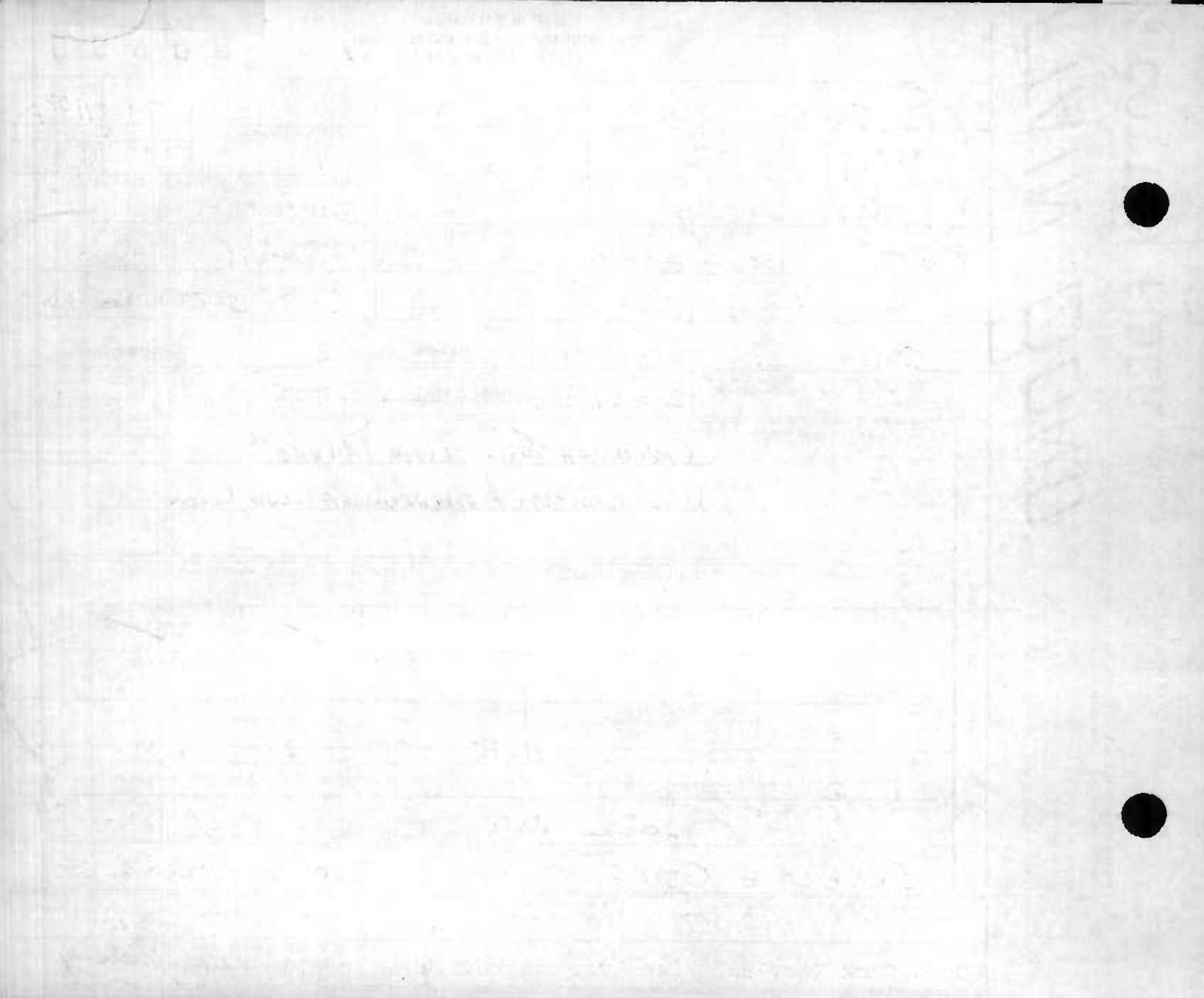
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  |   |  |   |   |  |   |   |  |
|---|--|--|--|---|--|---|---|--|---|---|--|
| 1. FOR STATE REGISTRAR  |  |  |  |   | REG. NO. 7 9 3 0 6 5 2                               |   |   |  |   |   |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>Grace J. C. Sowards  |  |  |  |   | 2a. DATE OF DEATH MONTH DAY YEAR<br>December 18, '79 |   |   | 2b. HOUR<br>M  |   |   |  |
| 3. SEX<br>Female  |  | 4. RACE<br>White   |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>10/2/1903  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>76   |   | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.   |   |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>N. Carolina  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.  |   |  |   |   |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>2132 Cambridge Street 21231 |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>House wife  |   | 12b. KIND OF BUSINESS OR INDUSTRY  |   |   |  |
| 13a. STATE<br>Maryland  |  |  |  |   | 13b. COUNTY  |   | 13c. CITY OR TOWN<br>Baltimore                                    |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   |  |
| 14. FATHER'S NAME<br>Dolphus L. Jennings  |  |  |  |   | 15. MOTHER'S MAIDEN NAME<br>Josie G. Joines          |   |   |  |   | 13e. STREET ADDRESS<br>2132 Cambridge St. 21231 |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>NO   |  | 16b. SOCIAL SECURITY NO<br>214-20-3687   |  | 17. INFORMANT<br>Lucy C. Hodges, Baltimore, Md. 21219   |  |   |   |  |   |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <u>Myocardial infarction, acute</u><br>2500 } DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>ASEVD</u><br>} DUE TO, OR AS A CONSEQUENCE OF (c) <u>Diabetes mellitus, myelomatosis</u> |  |  |  |   |  |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>8 hours<br>10 years<br>10+ years   |   |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |  |  |   |  |   |   |  |   |   |  |
| 19a. DATE OF OPERATION  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |   |  |   |   |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |  |   |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>7-22-76</u> , 19 <u>76</u> , to <u>11-27</u> , 19 <u>79</u> , that (I) (we) last saw the deceased alive on <u>11-27</u> , 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.                                       |  |  |  |   |  |   |   |  |   |   |  |
| 22b. SIGNATURE<br><u>W. Heine, M.D.</u>   |  |  | DEGREE   |   |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL STAFF<br>DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/> |   | 22c. DATE SIGNED   |   |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>HECTOR L. FELICIANO, M.D.  |  |  | 22e. ADDRESS<br>7200 N. POINT Rd. 21219                                |   |  |   |   |  |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial   |  |  | 23b. DATE<br>12/22/79  |   | 23c. NAME OF CEMETERY OR CREMATORY<br>Oak Lawn       |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore, Maryland |  |   |   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Duda-Ruck, Inc., Baltimore, Md. 21222   |  |  |  |   | 25a. DATE REC'D. BY REGISTRAR<br>DEC 21 1979         |   | 25b. REGISTRAR'S SIGNATURE<br><u>P. J. Helms</u>                  |  |   |   |  |



## MEDICAL CERTIFICATION

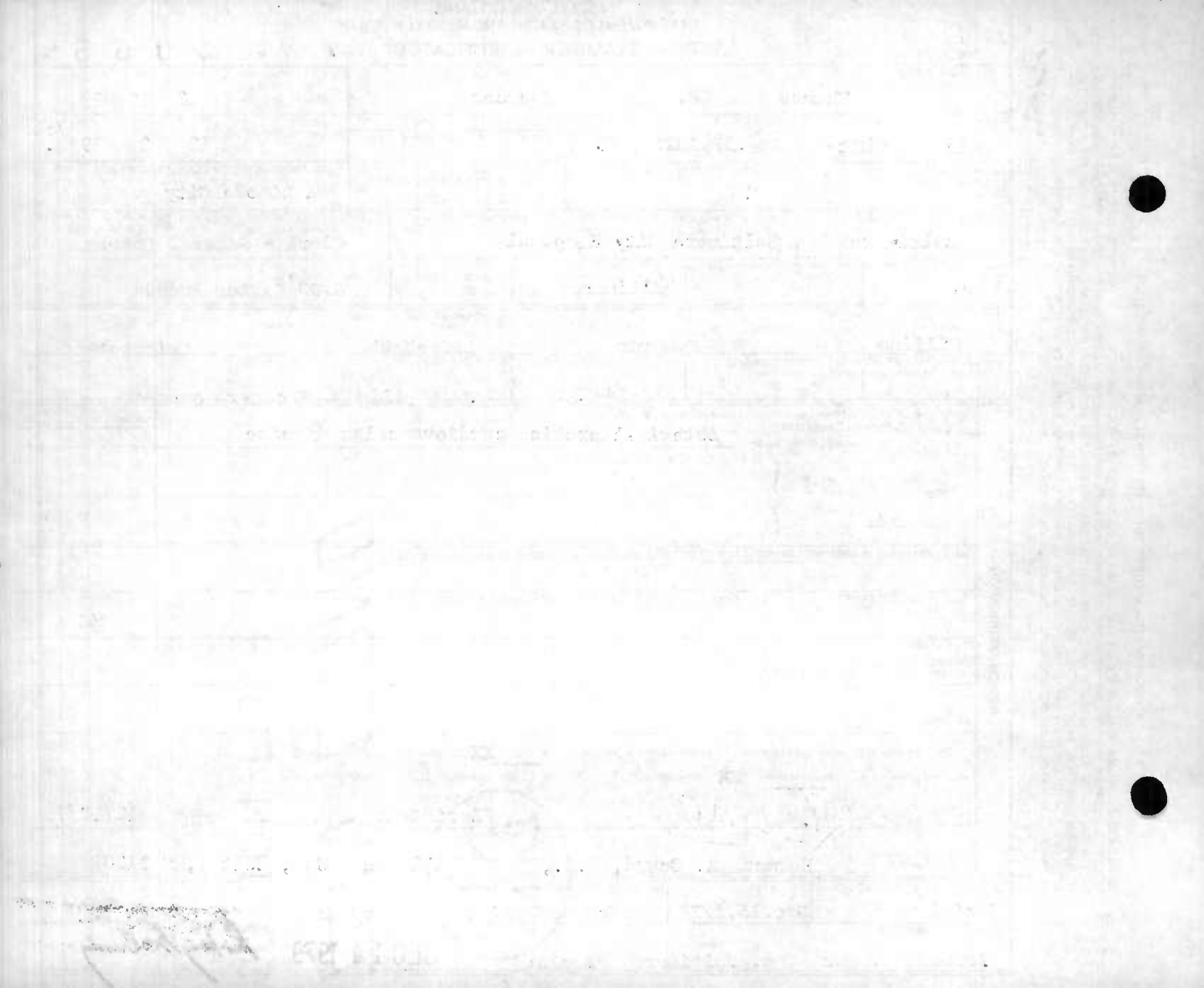




TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY OCCURS, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE MEDICAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM #M-3. RETAIN PAGE 1 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH                             |  |  |  |  |  |   |  |  |  | 9 REG. NO. 3 0 6 5 4                         |  |
|---|--|--|--|--|--|---|--|--|--|--|--|
| 1. FOR STATE REGISTRAR  |  | 1. DECEASED NAME (TYPE OR PRINT)   |  |  |  |   |  | 2a. DATE OF DEATH  |  | 2b. HOUR                                     |  |
|   |  | FIRST  |  | MIDDLE   |  | LAST  |  | KNOWN <input checked="" type="checkbox"/> ESTIMATED <input type="checkbox"/> |  | MONTH DAY YEAR                               |  |
|   |  | Thomas   |  | P.   |  | Spencer   |  | 12 12 19 79  |  | M  |  |
| 3. SEX  |  | 4. RACE  |  | 5. DATE OF BIRTH   |  | 6. AGE (IN YEARS)   |  | IF UNDER 24 HRS.   |  | 7. DATE PRONOUNCED DEAD                      |  |
| male  |  | white  |  | Aug. 17, 1920  |  | 59 YRS.   |  | MONTHS DAYS HOURS MIN.   |  | 12 12 19 79                                  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |  |  |  | 10. HOUR                                     |  |
| Md.   |  | USA  |  |  |  | Baltimore City  |  |  |  | 7:45 a. M                                    |  |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |  | 12b. KIND OF BUSINESS OR INDUSTRY                                   |  |  |  |  |  |
| Baltimore   |  | Baltimore City Hospital  |  | Clerk - General  |  | Motors  |  |  |  |  |  |
| 13a. STATE  |  | 13b. COUNTY  |  | 13c. CITY OR TOWN  |  | 13d. INSIDE CITY LIMITS?  |  | 13e. STREET ADDRESS  |  |  |  |
| Md.   |  |  |  | Baltimore  |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 6207 Carter Avenue   |  |  |  |
| 14. FATHER'S NAME   |  | 15. MOTHER'S MAIDEN NAME   |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)   |  | 16b. SOCIAL SECURITY NO.  |  | 17. INFORMANT  |  | ADDRESS                                      |  |
| FIRST MIDDLE LAST   |  | FIRST MIDDLE LAST  |  | yes  |  | 218-14-9656   |  | Mrs. Phyllis M. Spencer  |  | same   |  |
| William   |  | Elizabeth  |  |  |  |   |  | Helmstetter  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |  | 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |  | 20. AUTOPSY?  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART I DEATH WAS CAUSED BY:   |  |  |  |  |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  |  |  |  |
| IMMEDIATE CAUSE (a) 4292  |  |  |  | DUE TO, OR AS A CONSEQUENCE OF   |  |   |  |  |  |  |  |
| Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.                                       |  |  |  | (b)  |  |   |  |  |  |  |  |
|   |  |  |  | DUE TO, OR AS A CONSEQUENCE OF   |  |   |  |  |  |  |  |
|   |  |  |  | (c)  |  |   |  |  |  |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). |  |  |  |  |  |   |  |  |  |  |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH                 |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)  |  |   |  |  |  |  |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                              |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |   |  |  |  |  |  |
|   |  |  |  |  |  |   |  |  |  |  |  |
| 22a. I certify that I took charge of the remains described above, held an   |  | Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion   |  |  |  |   |  |  |  |  |  |
| death resulted from:  |  | Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |  |  |  |   |  |  |  |  |  |
| ACTUAL SIGNATURE  |  | TITLE (SPECIFY)  |  | DATE SIGNED  |  |   |  |  |  |  |  |
| H. R. Guard   |  | Assistant  |  | 12/12/79   |  |   |  |  |  |  |  |
| EXAMINER'S NAME (TYPE OR PRINT)   |  | ADDRESS  |  |  |  |   |  |  |  |  |  |
| Hormez R. Guard, M.D.,  |  | 111 Penn St., Balto., MD 21201   |  |  |  |   |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE                             |  |  |  |  |  |
| Burial  |  | Dec. 15, 1979  |  | Gardens of Faith   |  | Baltimore Md.   |  |  |  |  |  |
| 24. FUNERAL DIRECTOR NAME   |  | ADDRESS  |  | 25a. DATE REC'D. BY REGISTRAR  |  | 25b. REGISTRAR'S SIGNATURE  |  |  |  |  |  |
| Leonard J. Ruck Inc. Baltimore, Maryland  |  |  |  | DEC 14 1979  |  | R. J. Ruck  |  |  |  |  |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  | 7 9 3 0 6 5 5<br>REG. NO.  |  |  |  |  |  |
|---|--|---|--|--|--|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>August SPIES</b>  |  |   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>December 17, 1979</b>  |  |  |  | 2b. HOUR<br><b>6:35 a m</b>  |  |
| 3 SEX<br><b>Male</b>  |  | 4 RACE<br><b>White</b>  |  | 5 DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Oct. 30 1892</b>   |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br><b>87</b> YRS.                                     |  | # UNDER 1 YEAR<br>MONTHS DAYS<br># UNDER 24 HRS<br>HOURS MIN.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore, City</b> MD.                    |  |  |  |
| 10 CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Maryland General Hospital</b> |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Awning Maker</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>Maryland</b>  |  |   |  | 13b. COUNTY<br><b>Ann Arundel</b>  |  | 13c. CITY OR TOWN  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                            |  |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>? Spies</b>   |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Mary Sharnagel</b>   |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>no</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>214-20-3851</b>  |  | 17 INFORMANT ADDRESS<br><b>Elizabeth Kerr, 3423 Elmley Ave., Baltimore</b>   |  |  |  |  |  |
| 11 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <b>Cardiopulmonary Arrest</b>  |  |   |  |  |  |  |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH  |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost<br>(b) <b>Congestive Heart Failure</b><br>(c) <b>Multiple Decubiti</b>  |  |   |  |  |  |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |   |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION<br><b>December 14, 1979</b>  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>Decubitus Ulcer</b>  |  |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |  |  |  |  |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>November 2, 19 79</b> , to <b>December 17, 19 79</b> , that <input checked="" type="checkbox"/> (we) lost the deceased alive on <b>December 17, 19 79</b> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) did <input checked="" type="checkbox"/> view the body after death. |  |   |  |  |  |  |  |  |  |
| 22b. SIGNATURE<br><b>Krikor Tatoyan MD</b>  |  |   |  |  |  |  |  | 22c. DATE SIGNED<br><b>12/17/79</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Krikor Tatoyan, M.D.</b>  |  |   |  | 22e. ADDRESS<br><b>c/o Maryland General Hospital</b>   |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>Dec. 19, 1979</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Holy Redeemer</b>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Maryland</b>              |  |  |  |
| 24 FUNERAL DIRECTOR<br>NAME<br><b>Lilly &amp; Zeiler, Inc. 700 S. Conkling St.</b>  |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>DEC 18 1979</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>Robert McCreedy</b>                                 |  |  |  |

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December 17, 1979

Baltimore, City

Marland General Hospital

Baltimore

Cardiopulmonary Arrest

Compulsive Heart Failure

Multiple Decubiti

December 14, 1979 Decubitus Ulcer

November 2, 79 November 17, 79

12/17/79

C/O Marland General Hospital

Kirby Tatum, M.D.

12/17/79

DEC 1 1979

STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

7 9 3 0 6 5 6

1- FOR  
STATE  
REGISTRAR

REG. NO.

|   |  |  |   |  |  |  |  |  |   |  |  |
|---|--|--|---|--|--|--|--|--|---|--|--|
| 1 DECEASED NAME<br>(TYPE OR PRINT)  |  |  | FIRST MIDDLE LAST<br><b>EDWARD CLARENCE STAFFORD</b>  |  |  | 2a DATE OF DEATH MONTH DAY YEAR<br><b>12 25 79</b>   |  |  | 2b HOUR<br><b>4:55a</b>   |  |  |
| 3 SEX<br><b>MALE</b>  |  |  | 4 RACE<br><b>WHITE</b>  |  |  | 5 DATE OF BIRTH MONTH DAY YEAR<br><b>4 21 31</b>   |  |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br><b>48</b>   |  |  |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MARYLAND</b>   |  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  |  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE City</b>   |  |  |
| 10 CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>  |  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>VAMC BALTIMORE, MARYLAND 21218</b>  |  |  | 12a USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>International Furniture</b>  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Upholster</b>   |  |  |
| 13a STATE<br><b>MARYLAND</b>  |  |  | 13b. COUNTY<br><b>Balto.</b>  |  |  | 13c. CITY OR TOWN<br><b>BALTIMORE</b>  |  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                       |  |  |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Henry Stafford</b>  |  |  | 15 MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Margaret La Rue Wenck</b>  |  |  | 16a WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, IN OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>YES</b>  |  |  | 16b SOCIAL SECURITY NO.<br><b>NOXX KOREAN 213 26 5113</b>   |  |  |
| 17 INFORMANT<br>ADDRESS<br><b>Mr. Leslie Udovich 3 Dutrow Ct. 21237</b>   |  |  | 18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CARDIAC ARR 23 T</b><br><b>1629</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(b) <b>ROBBERY ARREST</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>LUNG CANCER</b> |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |  |   |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><b>N.A.</b>   |  |  |   |  |  |  |  |  |   |  |  |
| 19a DATE OF OPERATION<br><b>N.A.</b>  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>N.A.</b>   |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |
| 21a INJURY OCCURRED<br>WHILE AT WORK <input checked="" type="checkbox"/> NO WHILE AT WORK <input type="checkbox"/><br>OR CONTRIBUTING TO CAUSE OF DEATH<br>(IF EITHER, GIVE MEDICAL EXAMINER)<br><b>N.A.</b>  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>N.A.</b>  |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)<br><b>N.A.</b>  |  |  | 21d. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br><b>N.A.</b>  |  |  |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>NOVEMBER 5 19 79</b> , to <b>DECEMBER 25 19 79</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>DECEMBER 25 19 79</b> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) did <input type="checkbox"/> (not) view the body after death. |  |  |   |  |  |  |  |  |   |  |  |
| 22b. SIGNATURE<br><b>D. Woronow</b>   |  |  | DEGREE<br><b>MD</b>   |  |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>                 |  |  | 22c. DATE SIGNED<br><b>12/26/79</b>   |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>WORONOW</b>   |  |  | 22e. ADDRESS<br><b>Lock Raven VA Hospital</b>   |  |  |  |  |  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>  |  |  | 23b. DATE<br><b>12-28-79</b>  |  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Mem. Park</b>   |  |  | 23d. LOCATION<br>COUNTY STATE<br><b>Balto. Howard Md.</b>   |  |  |
| 24 FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Leonard J Ruck Inc. 5305 Harford Rd 21214</b>   |  |  |   |  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>DEC 26 1979</b>  |  |  | 25b. REGISTRAR'S SIGNATURE<br><b>Robert M. Brady</b>  |  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

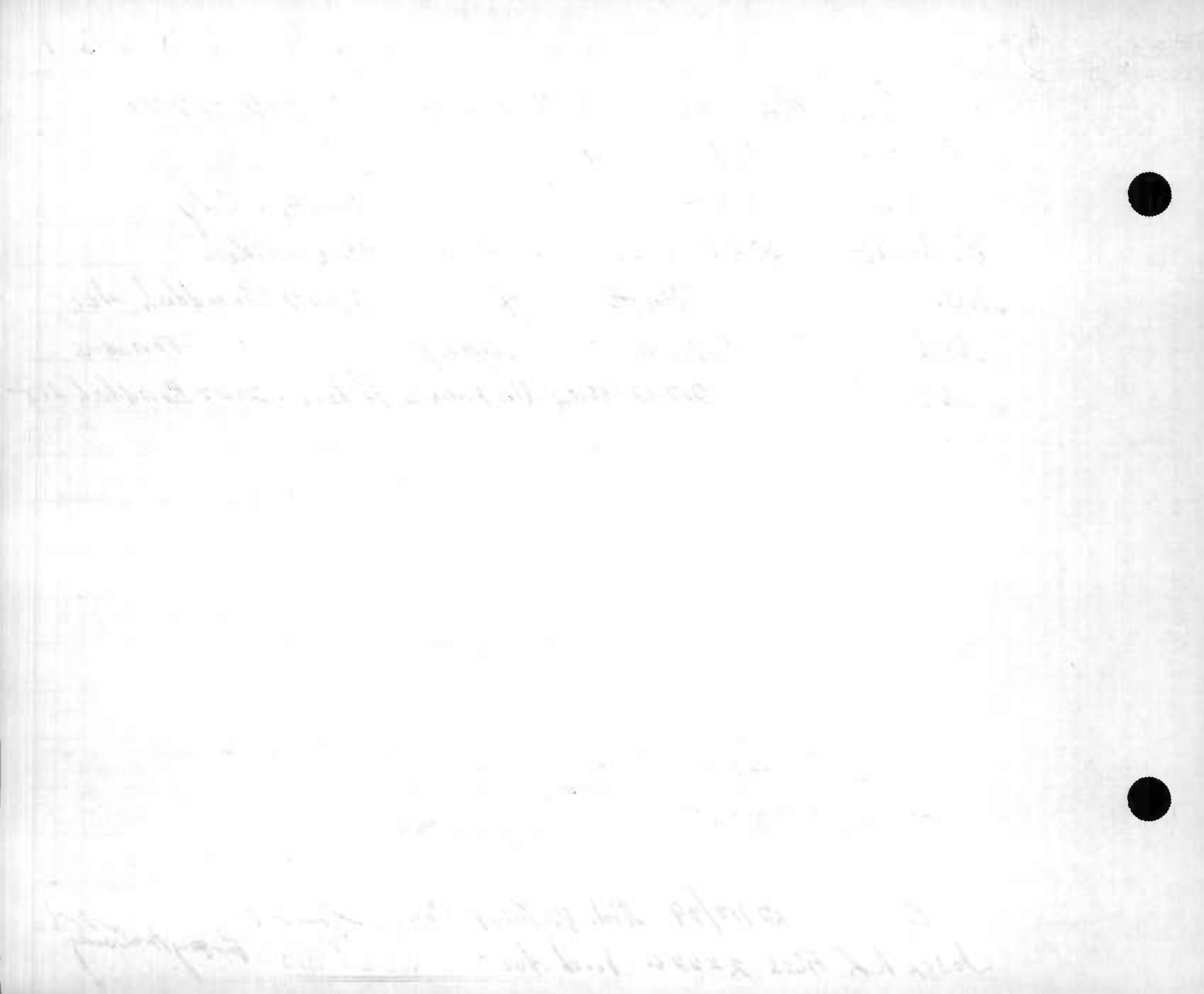
STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

FOR  
1 - STATE  
REGISTRAR

REG. NO.

|   |  |  |   |   |  |   |  |  |  |
|---|--|--|---|---|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>BERTHA W. STANDARD</b>   |  |  | 2a. DATE OF DEATH<br>MONTH <b>12</b> - DAY <b>12</b> - YEAR <b>79</b> |   |  | 2b. HOUR<br>M   |  |  |  |
| 3. SEX<br><b>Female</b>   |  | 4. RACE<br><b>col</b>  |   | 5. DATE OF BIRTH<br>MONTH <b>JULY</b> DAY <b>25</b> YEAR <b>1919</b>  |  | 6. AGE (IN YEARS (LAST BIRTHDAY))<br><b>79</b>  |  | 7. IF UNDER 1 YEAR<br>MONTHS <b>79</b> DAYS <b>79</b> HOURS <b>79</b> MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>VA.</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Balti. City</b> MD.                                  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>2027 BRADDOISH AVE</b> |   |   |  | 12a. USUAL OCCUPATION<br>(TYPE IF WORK FOR MOST OF WORKING LIFE)<br><b>HOME MAKER</b>           |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| 13a. STATE<br><b>MD.</b>  |  | 13b. COUNTY  |   | 13c. CITY OR TOWN<br><b>Balti</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>2027 Braddish Ave</b>  |  |
| 14. FATHER'S NAME<br>FIRST <b>Ned</b> MIDDLE <b>Stewart</b> LAST <b>Stewart</b>   |  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>MARY</b> MIDDLE <b>Frances</b> LAST <b>Frances</b>   |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>217-12-8570</b>   |   | 17. INFORMANT<br>ADDRESS<br><b>Mrs Frances Hudson - 2027 Braddish Ave</b>   |  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Acute myocardial infarction</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Arteriosclerotic heart disease</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>410 -</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |  |   |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>5 minutes</b><br><b>Several years</b>                                   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |  |   |   |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                       |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>1964</b> , to <b>Dec 12 1979</b> , that (I) (we) lost<br>saw the deceased alive on <b>Dec 3 1979</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated<br>above. (If deceased) (did not) view the body after death.   |  |  |   |   |  |   |  |  |  |
| 22b. SIGNATURE<br><b>SEYMOUR RUBINOW</b>  |  |  |   | DEGREE  |  |   |  | 22c. DATE SIGNED<br><b>12/18/79</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>SEYMOUR RUBINOW</b>   |  |  |   | 22e. ADDRESS<br><b>7111 Park Heights Rd</b>   |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY) <b>B</b>   |  | 23b. DATE<br><b>12/17/79</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>MD. National Cem.</b>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Larver Md.</b>                                 |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME <b>Joseph L. Russ</b> ADDRESS <b>2222 W. North Ave</b>   |  |  |   | 25a. DATE REC'D. BY REGISTRAR<br><b>DEC 21 1979</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>Anthony H. H. H.</b>   |  |  |  |







STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

79 30658

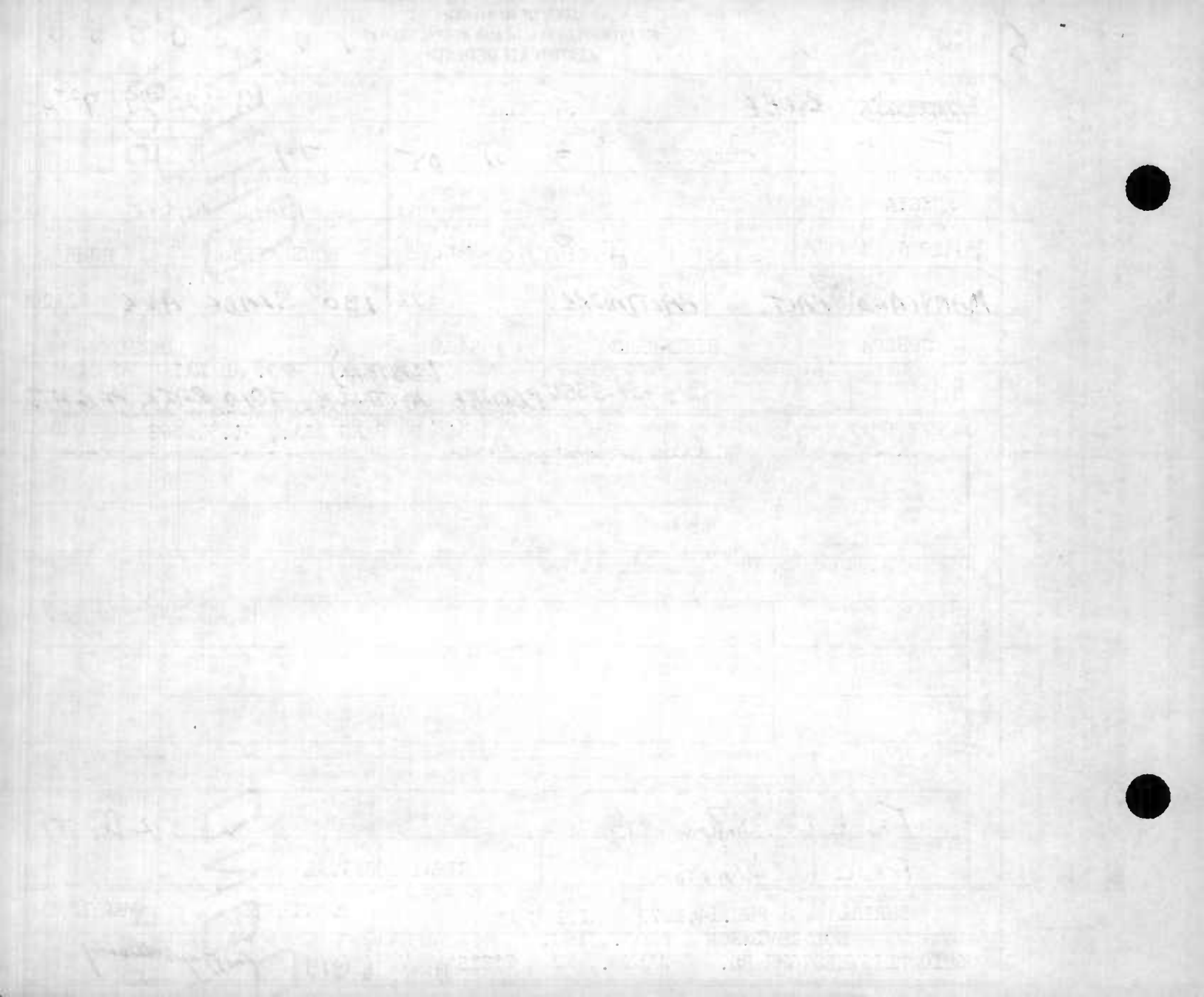
FOR  
1. STATE  
REGISTRAR

REG. NO.

|   |  |   |  |   |  |
|---|--|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><del>XXXXXXXXXX</del> <b>BESE</b><br>STATELAND   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>12-12-79  |   | 2b. HOUR<br>9 <sup>25</sup> A.M.   |
| 3. SEX<br>FEMALE  | 4. RACE<br>CAUCASIAN   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>3 11 05   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>74 YRS.                                | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>RUSSIA   | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.   |   |  |
| 10. CITY OR TOWN OF DEATH<br>BALTO. CITY  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>SINAI HOSPITAL-BALTO. |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>HOUSEWIFE  | 12b. KIND OF BUSINESS OR INDUSTRY<br>AT HOME                              |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>MARYLAND  |  |   | 13b. COUNTY<br>BALT.   | 13c. CITY OR TOWN<br>BALTIMORE  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                            |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>JOSEPH EISENBERG  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>SARAH UNKNOWN   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>NO  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>213-34-3556   | 17. INFORMANT<br><del>XXXXXXXXXX</del> MRS. ADALAI NE MONCARY<br>1560 S. OCEAN BLVD. APT. 2508<br>POMPAHO BEA., FL. 33062                                   |  |   |  |
| 18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <u>Cardiopulmonary arrest</u><br>4275<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |  |   |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a.  |  |   |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |   |  |   |  |
| 22b. SIGNATURE<br>Frank W. Braxton, MD  |  |   | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |   | 22c. DATE SIGNED<br>12 Dec 79  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>FRANK W. BRAXTON   |  |   | 22e. ADDRESS<br>SINAI HOSPITAL   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>BURIAL   | 23b. DATE<br>DEC. 14, 1979   | 23c. NAME OF CEMETERY OR CREMATORY<br>AITZ CHAIM  |  | 23d. LOCATION<br>BALTIMORE COUNTY MARYLAND                                |  |
| 24. FUNERAL DIRECTOR<br>NAME SOL LEVINSON & BROS., INC.<br>6010 REISTERSTOWN RD.  |  |   | 25a. DATE REC'D. BY REGISTRAR<br>DEC 14 1979   |   |  |
| 25b. REGISTRAR'S SIGNATURE<br>[Signature]   |  |   |  |   |  |

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 2 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.



DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. FOR  
STATE  
REGISTRAR

|  |  |   |  |   |                              |  |  |
|--|--|---|--|---|------------------------------|--|--|
| 1. DECEASED NAME (FIRST, MIDDLE, LAST)<br><b>ROBERT MARTIN STAUFFER</b>        |  |   | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>12-6-79</b> |   | 2b. HOUR<br><b>7:30 P.M.</b> |  |  |
| 3. SEX<br><b>Male</b>  |  | 4. RACE<br><b>WHITE</b>   |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>NOV. 11, 1940</b>   |                              | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>39 YRS.</b>                  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>BALTIMORE, MD.</b>             |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                              | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY, MD.</b> |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE, MD.</b>                             |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>UNIVERSITY of MD. HOSPITAL</b> |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>COUNTER-MAN</b>   |                              | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>MARY MERVIS CO.</b>        |  |
| 13a. STATE<br><b>MD.</b>   |  |   |  | 13b. COUNTY<br><b>BALTIMORE</b>   |                              | 13c. CITY OR TOWN<br><b>ESSEX</b>                                  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>MARTIN STAUFFER</b>                  |  |   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>LILLIAN BURES</b>  |                              |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br><b>NO</b> |  | 16b. SOCIAL SECURITY NO.<br><b>220-36-3017</b>  |  | 17. INFORMANT ADDRESS<br><b>SHARON D. STAUFFER ; 749 SEAWALL RD. ESSEX, 21221, MD.</b>  |                              |  |  |

|   |  |  |
|---|--|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CARDIORESPIRATORY ARREST</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>INCREASING INTRACRANIAL PRESSURE</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>GLIOMASTOMA</b> |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
|---|--|--|

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

|  |  |  |  |   |  |  |  |
|--|--|--|--|---|--|--|--|
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>10/17</b> , 19 <b>79</b> , to <b>11/6</b> , 19 <b>79</b> , that (I) (we) lost saw the deceased alive on <b>19</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |   |  |  |  |
| 22b. SIGNATURE<br><b>Edwin H. Bellis</b>   |  | DEGREE<br><b>MD.</b>   |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br><b>12/6/79</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Edwin H. Bellis</b>  |  | 22e. ADDRESS   |  |   |  |  |  |

|  |  |  |  |  |  |   |  |
|--|--|--|--|--|--|---|--|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>BURIAL</b>               |  | 23b. DATE<br><b>12-10-79</b>                   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>WOODLAWN CEMETERY</b> |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>2130 WOODLAWN DRIVE, BA., CO., MD.</b> |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Charles S. Seiler &amp; Son, Inc.</b> |  | 6224 EASTERN AVE.<br><b>BALTO., 21224, MD.</b> |  | 25a. DATE REC'D BY REGISTRAR<br><b>DEC 11 1979</b>             |  | 25b. REGISTRAR'S SIGNATURE<br><b>Sharon D. Stauffer</b>                                 |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed within 72 hours after death. Page 3 should be filed within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of same.

750-20-95

5-5

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE FORMS 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PA 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| Items #10a-22a Film G539 1/24/80 STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH   |  |                      |  |   |  |  |  |  |  | REG. NO. 30660  |  |                           |  |
|--|--|----------------------|--|---|--|--|--|--|--|---|--|---------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Willie Steele Jr.</b>   |  |                      |  |   |  |  |  |  |  | 2a. DATE KNOWN OF DEATH<br>ESTIMATED <input checked="" type="checkbox"/> MONTH <b>12</b> DAY <b>15</b> YEAR <b>1979</b> |  | 2b. HOUR <b>4:35</b> P.M. |  |
| 3. SEX <b>male</b>   |  | 4. RACE <b>black</b> |  | 5. DATE OF BIRTH<br>MONTH <b>5</b> DAY <b>31</b> YEAR <b>1952</b>   |  | 6. AGE (IN YEARS)<br>(LAST BIRTHDAY) <b>27</b> YRS.  |  | IF UNDER 1 YR. MONTHS <b>0</b> DAYS <b>0</b>   |  | IF UNDER 24 HRS. HOURS <b>0</b> MIN <b>0</b>  |  |                           |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Md.</b>   |  |                      |  | 7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>  |  |  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. <b>BALTIMORE CITY</b> OR COUNTY OF DEATH <b>Baltimore City</b> MD.   |  |                           |  |
| 10. CITY OR TOWN OF DEATH <b>Baltimore</b>   |  |                      |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>University Hospital</b> |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |                           |  |
| 13a. STATE <b>Md.</b>  |  |                      |  | 13b. COUNTY <b>City</b>   |  | 13c. CITY OR TOWN <b>Balto.</b>  |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 13e. STREET ADDRESS <b>4637 Coleherne Rd.</b>   |  |                           |  |
| 14. FATHER'S NAME<br>FIRST <b>Willie</b> MIDDLE <b>Steele</b> LAST <b>Sr.</b>  |  |                      |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>Dorothy</b> MIDDLE <b>Anderson</b> LAST <b>Anderson</b> |  |  |  |   |  |                           |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN) <b>No</b>  |  |                      |  | 16b. SOCIAL SECURITY NO. <b>215-60-5198</b>   |  | 17. INFORMANT ADDRESS <b>4637 Dorothy M. Johnson Coleherne Rd.</b>                           |  |  |  |   |  |                           |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1 DEATH WAS CAUSED BY: <b>3049</b> IMMEDIATE CAUSE (a) <b>Narcotism</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____   |  |                      |  |   |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |                           |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).  |  |                      |  |   |  |  |  |  |  |   |  |                           |  |
| 19a. DATE OF OPERATION   |  |                      |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |  |  |  |  |  | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                     |  |                           |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |  |                      |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. <b>19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)                |  |  |  |   |  |                           |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  |                      |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |  |  |   |  |                           |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |  |                      |  |   |  |  |  |  |  |   |  |                           |  |
| ACTUAL SIGNATURE <b>Hormez R. Guard</b>  |  |                      |  | TITLE (SPECIFY) <b>Assistant</b>  |  |  |  | DATE SIGNED <b>12/16/79</b>  |  |   |  |                           |  |
| EXAMINER'S NAME (TYPE OR PRINT) <b>Hormez R. Guard, M.D.</b>   |  |                      |  | ADDRESS <b>111 Penn St. Balto., MD 21201</b>  |  |  |  |  |  |   |  |                           |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>  |  |                      |  | 23b. DATE <b>12/22/79</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY <b>Kings Mem. Park</b>                                    |  |  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE <b>Randallstown Balto. Md.</b>   |  |                           |  |
| 24. FUNERAL DIRECTOR<br>NAME <b>Charles A. Rice</b> ADDRESS <b>1300 Eutaw Place</b>  |  |                      |  |   |  | 25a. DATE REC'D. BY REGISTRAR <b>DEC 21 1979</b>   |  | 25b. REGISTRAR'S SIGNATURE <b>R. H. H. H.</b>  |  |   |  |                           |  |





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  |   |  |  |  |  |  |
|---|--|--|--|---|--|--|--|--|--|
| 1. FOR STATE REGISTRAR  |  | REG. NO. 9 30661   |  |   |  |  |  |  |  |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br>Stale Mildred E. Steele   |  |  |  |   |  | 2a. DATE OF DEATH MONTH DAY YEAR<br>12 31 79   |  | 2b. HOUR<br>12 25 AM   |  |
| 3. SEX<br>Female  |  | 4. RACE<br>White   |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>2 16 95  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>84 YRS  |  | 7. IF UNDER 1 YEAR MONTHS DAYS<br>IF UNDER 24 HRS. HOURS MIN.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>BALTIMORE  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD.                           |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>BALTO.   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>MERCY HOSPITAL |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Waitress            |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Restaurant  |  |
| 13a. STATE MD.  |  |  |  |   |  | 13b. COUNTY  |  | 13c. CITY OR TOWN<br>BALTO.  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>John Bankard   |  |  |  |   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Annie Smith                            |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>No   |  | 16b. SOCIAL SECURITY NO.<br>220.14.4992  |  | 17. INFORMANT<br>Helen L. Ball  |  | ADDRESS<br>Dundalk Md. 95 Kinship Rd. 21222  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <u>CARDIOGENIC SHOCK</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Acute myocardial infarction</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>ASCVD</u>  |  |  |  |   |  |  |  |  |  |
| APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>12 hours<br>14 hours<br>> 10 years  |  |  |  |   |  |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |  |  |   |  |  |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |  |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>12/30</u> , 19 <u>79</u> , to <u>12/31</u> , 19 <u>79</u> , that (I) (we) last saw the deceased alive on <u>12/30</u> , 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |   |  |  |  |  |  |
| 22b. SIGNATURE<br>J. Snyder MD  |  |  |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>        |  |  |  | 22c. DATE SIGNED<br>12/31/79   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>J. SNYDER  |  |  |  | 22e. ADDRESS<br>MERCY HOSPITAL BALTO. MD.   |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial   |  | 23b. DATE<br>1/2/1980  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Woodlawn Cemetery   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br>Baltimore Md.                             |  |  |  |
| 24. FUNERAL DIRECTOR NAME<br>Walter Brooks Bradley Inc.   |  |  |  | ADDRESS<br>Dundalk Md   |  | 25a. DATE REC'D. BY REGISTRAR<br>JAN 7 1980  |  | 25b. REGISTRAR'S SIGNATURE<br>Cathy McCreedy   |  |





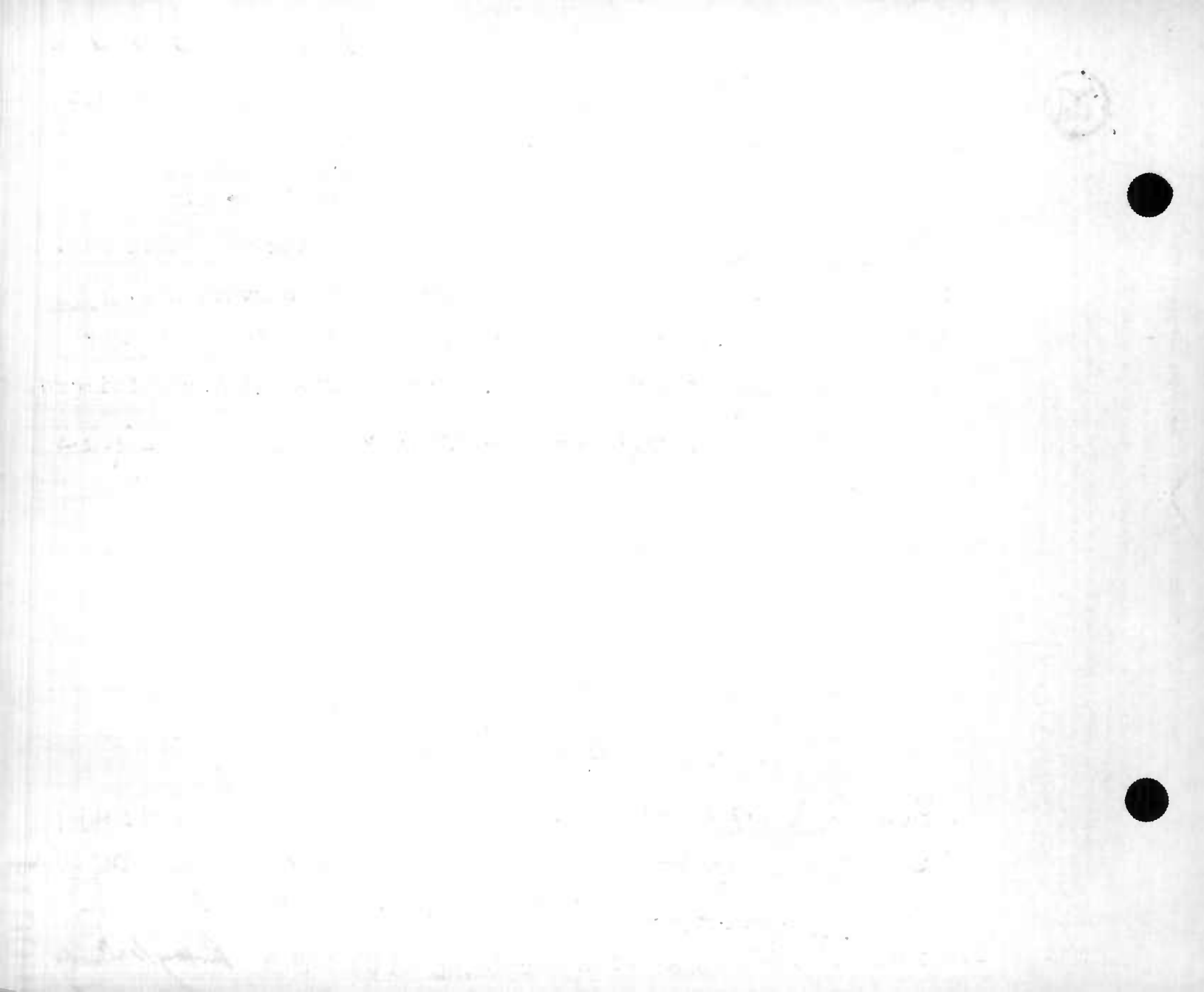
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the doctor or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  |  |  |   |  |  |  | 79 30662            |     |            |           |
|---|--|--|--|--|--|---|--|--|--|---------------------|-----|------------|-----------|
| 1. FOR STATE REGISTRAR  |  | REG. NO.   |  |  |  |   |  |  |  |                     |     |            |           |
| 1. DECEASED NAME (TYPE OR PRINT)  |  | FIRST  |  | MIDDLE   |  | LAST  |  | 2a. DATE OF DEATH  |  | MONTH               | DAY | YEAR       | 2b. HOUR  |
| Margaret Ann A. Steffen   |  |  |  |  |  |   |  | 12 23 79   |  |                     |     |            | 7:25 P.M. |
| 3. SEX  |  | 4. RACE  |  | 5. DATE OF BIRTH   |  | 6. AGE (IN YEARS LAST BIRTHDAY)                                     |  | IF UNDER 1 YEAR  |  | IF UNDER 24 HRS.    |     |            |           |
| female  |  | white  |  | Sept. 13, 1919   |  | 60  |  | MONTHS   |  | DAYS                |     | HOURS MIN. |           |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |  |  |  |                     |     |            |           |
| MD  |  | USA  |  |  |  | Baltimore City  |  |  |  |                     |     | MD.        |           |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |  | 12b. KIND OF BUSINESS OR INDUSTRY                                   |  |  |  |                     |     |            |           |
| Baltimore   |  | John F. Deaton - Medical Center  |  | Beautician   |  | self emp.   |  |  |  |                     |     |            |           |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  | 13a. STATE   |  | 13b. COUNTY  |  | 13c. CITY OR TOWN   |  | 13d. INSIDE CITY LIMITS?                                       |  | 13e. STREET ADDRESS |     |            |           |
| MD  |  | LAA Co.  |  | Pasadena   |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  | 925 Longview Ave.   |     |            |           |
| 14. FATHER'S NAME   |  | 15. MOTHER'S MAIDEN NAME   |  |  |  |   |  |  |  |                     |     |            |           |
| William Stone Hanson  |  | Frances Virginia Sanders   |  |  |  |   |  |  |  |                     |     |            |           |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)   |  | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT  |  | ADDRESS   |  |  |  |                     |     |            |           |
| NO  |  | XXXXXXXXXX   |  | 218/01/5223  |  | Mrs. Alice Riddle (sister)  |  | Baltimore, MD  |  |                     |     |            |           |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Lymphoma of BRAIN<br>2028<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) DUE TO, OR AS A CONSEQUENCE OF<br>(c) DUE TO, OR AS A CONSEQUENCE OF<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>2 years |  |  |  |  |  |   |  |  |  |                     |     |            |           |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |  |  |  |  |   |  |  |  |                     |     |            |           |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  |  | 20a. AUTOPSY?   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |  |                     |     |            |           |
|   |  |  |  |  |  | YES <input type="checkbox"/> NO <input type="checkbox"/>            |  | YES <input type="checkbox"/> NO <input type="checkbox"/>       |  |                     |     |            |           |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)   |  |   |  |  |  |                     |     |            |           |
|   |  | HOUR A.M. MONTH DAY YEAR   |  |  |  |   |  |  |  |                     |     |            |           |
|   |  | P.M. 19  |  |  |  |   |  |  |  |                     |     |            |           |
| 21d. INJURY OCCURRED  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  | 21f. LOCATION  |  |   |  |  |  |                     |     |            |           |
| WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |  |  | STREET   |  | CITY OR TOWN  |  | COUNTY   |  | STATE               |     |            |           |
|   |  |  |  |  |  |   |  |  |  |                     |     |            |           |
| 22a. I certify that (I) (this hospital) attended the deceased from 11/16/79 to 12/23/79, that (I) (we) lost saw the deceased alive on 11/22/79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |  |  |  |  |   |  |  |  |                     |     |            |           |
| 22b. SIGNATURE  |  | DEGREE   |  | 22c. DATE SIGNED   |  |   |  |  |  |                     |     |            |           |
| Paul Schmiedel MD   |  |  |  | 12/24/79   |  |   |  |  |  |                     |     |            |           |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  | 22e. ADDRESS   |  |  |  |   |  |  |  |                     |     |            |           |
| Paul Schmiedel  |  | 1406 Croen Heafury Glen Burnie   |  |  |  |   |  |  |  |                     |     |            |           |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION   |  |  |  |                     |     |            |           |
| Burial  |  | Dec. 27, 1979  |  | Sacred Heart Cem.  |  | Lapata, Charles, MD   |  |  |  |                     |     |            |           |
| 24. FUNERAL DIRECTOR  |  | 24a. NAME  |  | 24b. ADDRESS   |  | 25a. DATE REC'D. BY REGISTRAR                                       |  | 25b. REGISTRAR'S SIGNATURE                                     |  |                     |     |            |           |
| Singleton Funeral Home  |  | Glen Burnie, MD  |  |  |  | DEC 28 1979   |  | [Signature]  |  |                     |     |            |           |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |                  |  |  |   |                    |
|---|------------------|--|--|---|--------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>RUTH L. STEIN     |                  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>12 7 79 |   | 2b. HOUR<br>9 P.M. |
| 3. SEX<br>FEMALE  | 4. RACE<br>WHITE | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>01 22 07 |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>72 YRS.  |                    |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>MARYLAND                         |                  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.         |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                    |
| 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD.                    |                  | 10. CITY OR TOWN OF DEATH<br>BALTIMORE         |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>SINAI HOSPITAL                                 |                    |
| 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>HOUSEWIFE |                  | 12b. KIND OF BUSINESS OR INDUSTRY<br>AT HOME   |  | 13a. STREET ADDRESS<br>APT. 9<br>3 STONEHENGE CIR. 21208  |                    |

|   |  |   |  |  |  |
|---|--|---|--|--|--|
| 13a. STATE<br>MARYLAND                                    |  | 13b. COUNTY<br>BALTIMORE  |  | 13c. CITY OR TOWN<br>BALTIMORE   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>BENJAMIN SINGER |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>BESSIE AZEROF                    |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>NO |  |
| 16b. SOCIAL SECURITY NO.<br>218-32-3225                   |  | 17. INFORMANT<br>ADDRESS #21208<br>MR. SOLOMON E. STEIN 3 STONEHENGE CIR., APT. 9 |  |  |  |

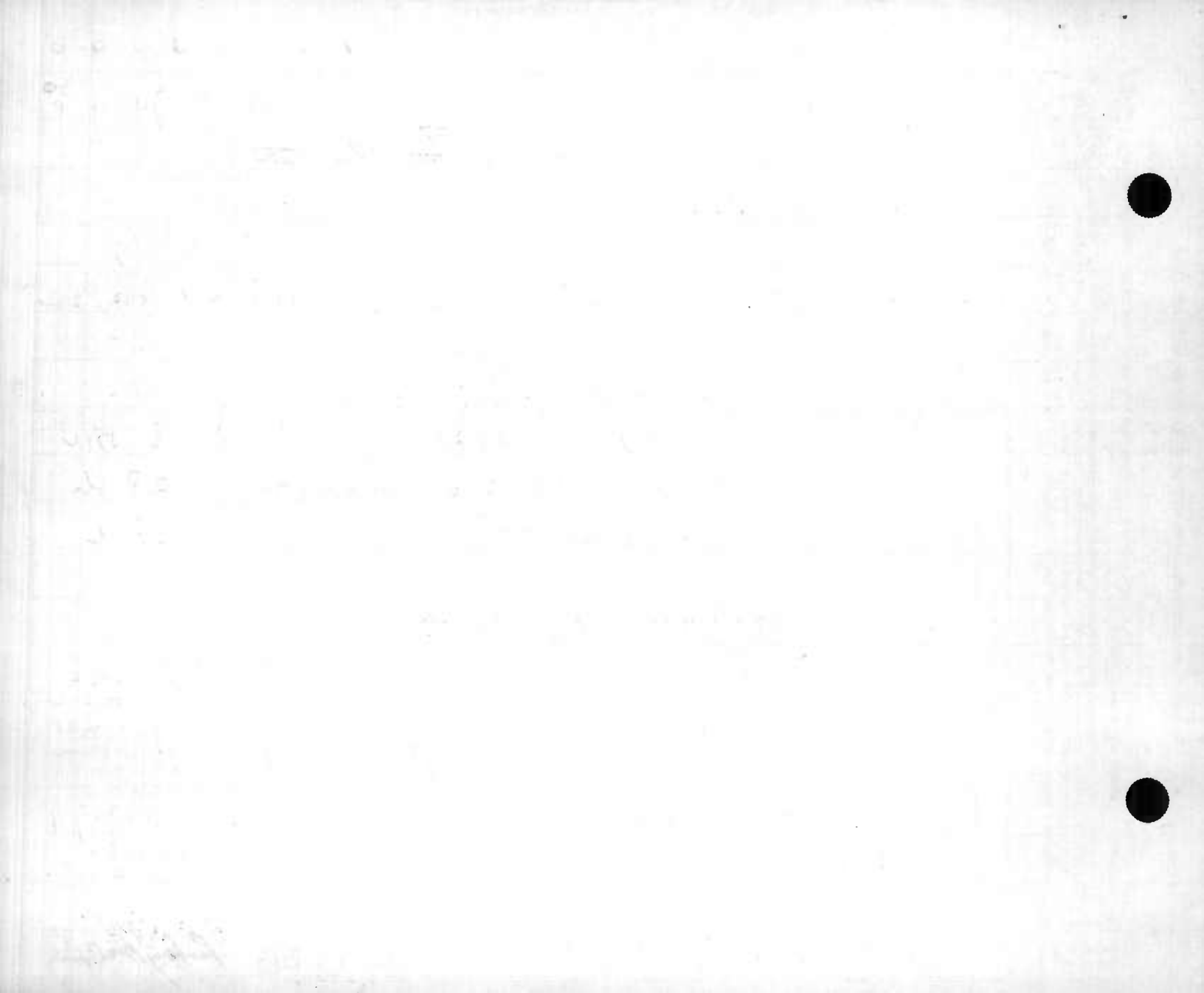
|  |  |  |
|--|--|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) CARDIAC ARREST<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) RIGHT SUBDURAL HEMATOMA<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) HEAD TRAUMA |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br>3 MIN<br>28 Hk<br>28 Hk |
|--|--|--|

|   |  |  |  |   |  |
|---|--|--|--|---|--|
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):  |  |  |  |   |  |
| 19a. DATE OF OPERATION<br>12-6-79   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br>DRAINAGE RIGHT SUBDURAL HEMATOMA |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  |
| 21a. ACCIDENT WAS UNDERLYING <input checked="" type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>5:30 P.M. 12 6 79                 |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)<br>PATIENT FELL FROM STONE STAIR WELLS |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)<br>AT HOME    |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br>3 STONEHENGE CIR. 21208 BALTIMORE MARYLAND                       |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 12-6-1979 to 12-7-1979, that (I) (we) last saw the deceased alive on 12-7-1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |   |  |
| 22b. SIGNATURE<br>N. VERSTEEG   |  | DEGREE<br>F.A.   |  | 22c. DATE SIGNED<br>12-7-79   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>VERSTEEG   |  | 22e. ADDRESS<br>SINAI HOSPITAL BALTIMORE 21215.                                      |  |   |  |

|   |  |  |  |   |  |
|---|--|--|--|---|--|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>BURIAL         |  | 23b. DATE<br>12-9-79   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>ANSHE EMUNAH-ATTZ CHAIN |  |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>BALTIMORE MD. |  | 24. FUNERAL DIRECTOR<br>NAME SOL LEVINSON & BROS., INC.<br>ADDRESS 6010 REISTERSTOWN RD., BALTO., MD 21215 |  |   |  |
| 25a. DATE REC'D. BY REGISTRAR<br>DEC 13 1979                |  | 25b. REGISTRAR'S SIGNATURE<br>[Signature]  |  |   |  |

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(VRA 15, 4) 7/78



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  |  |  |   |  |                                  |  |  |  |
|---|--|--|--|--|--|---|--|----------------------------------|--|--|--|
| 1. FOR STATE REGISTRAR  |  | 7930664  |  | REG. NO.   |  |   |  |                                  |  |  |  |
| 1. DECEASED NAME (TYPE OR PRINT)  |  | FIRST  |  | MIDDLE   |  | LAST  |  | 2a. DATE OF DEATH MONTH DAY YEAR |  | 2b. HOUR   |  |
| PASQUALE  |  | STELLA   |  |  |  |   |  | 12-28-79                         |  | 10 AM  |  |
| 3 SEX   |  | 4 RACE   |  | 5 DATE OF BIRTH MONTH DAY YEAR   |  | 6 AGE (IN YEARS LAST BIRTHDAY)  |  | 7. IF UNDER 1 YEAR MONTHS DAYS   |  | 8. IF UNDER 24 HRS. HOURS MIN.   |  |
| Male  |  | White  |  | March 9, 1908  |  | 71 YRS.   |  |                                  |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH  |  |                                  |  |  |  |
| West Virginia   |  | USA  |  |  |  | Baltimore City, MD.   |  |                                  |  |  |  |
| 10 CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |                                  |  |  |  |
| Baltimore   |  | John Z. Deaton Medical Center  |  | Inspector  |  | Beth Steel  |  |                                  |  |  |  |
| 13a. STATE  |  | 13b. COUNTY  |  | 13c. CITY OR TOWN  |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |  | 13e. STREET ADDRESS              |  |  |  |
| Maryland  |  | Baltimore  |  |  |  |   |  | 814 N. Kenwood Avenue            |  |  |  |
| 14 FATHER'S NAME FIRST MIDDLE LAST  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST   |  |  |  |   |  |                                  |  |  |  |
| Antonio Stella  |  | Maria Slatti   |  |  |  |   |  |                                  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)   |  | 16b. SOCIAL SECURITY NO  |  | 17 INFORMANT   |  | ADDRESS   |  |                                  |  |  |  |
| No  |  | 213-07-4691  |  | George Stella  |  | Baltimore 7917 St. Bridget Lane 21222   |  |                                  |  |  |  |
| 11 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |  |  |  |  |  |   |  |                                  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |
| PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u>   |  |  |  |  |  |   |  |                                  |  | 3 mins.  |  |
| 4409 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last  |  |  |  |  |  |   |  |                                  |  | DUE TO, OR AS A CONSEQUENCE OF (b) <u>old atherosclerotic disease and infarcts</u> years - |  |
|   |  |  |  |  |  |   |  |                                  |  | DUE TO, OR AS A CONSEQUENCE OF (c) _____   |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <u>Fever of unknown origin - Platelets - Cerebral Infarcts</u>   |  |  |  |  |  |   |  |                                  |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |                                  |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |   |  |                                  |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |   |  |                                  |  |  |  |
| 22. I certify that (I) (the hospital) attended the deceased from <u>12-21-79</u> 19 <u>79</u> , to <u>12-28</u> 19 <u>79</u> , that (I) (we) last saw the deceased alive on <u>12-26-79</u> 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |   |  |                                  |  |  |  |
| 22a. SIGNATURE  |  | DEGREE   |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>               |  | 22c. DATE SIGNED  |  |                                  |  |  |  |
| <u>[Signature]</u>  |  |  |  |  |  | Dec. 29, 1979   |  |                                  |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  | 22e. ADDRESS   |  |  |  |   |  |                                  |  |  |  |
| 103 EBLEY III MD  |  | 3809 Greenmount Ave  |  |  |  |   |  |                                  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE   |  |                                  |  |  |  |
| Burial  |  | Dec. 31, 79  |  | Holy Redeemer Cem  |  | Baltimore, Maryland   |  |                                  |  |  |  |
| 24 FUNERAL DIRECTOR NAME  |  | ADDRESS  |  | 25a. DATE REC'D. BY REGISTRAR  |  | 25b. REGISTRAR'S SIGNATURE  |  |                                  |  |  |  |
| Dippel Brothers, Inc.   |  | 7110 Belair Rd. 21206  |  | DEC 31 1979  |  | <u>[Signature]</u>  |  |                                  |  |  |  |

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| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  |   |  |  |  |   |  |
|---|--|---|--|---|--|--|--|---|--|
| 1- FOR STATE REGISTRAR  |  |   |  |   |  |  |  |   |  |
| 1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br><b>ISABEL A. STEPHANS</b>  |  |   |  |   | 2a. DATE OF DEATH MONTH DAY YEAR 2b. HOUR<br><b>12 23 79 138 M</b> |  |  |   |  |
| 3 SEX<br><b>F</b>   |  | 4 RACE<br><b>W</b>  |  | 5 DATE OF BIRTH MONTH DAY YEAR<br><b>8 28 02</b>  |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br><b>77</b> YRS.   |  | 7 UNDER 1 YEAR 7 UNDER 24 HRS. MONTHS DAYS HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>U.S.A</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A</b>  |  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE</b> MD.                                  |  |   |  |
| 10 CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN HOME FACILITY, GIVE STREET ADDRESS)<br><b>Sinai Hospital</b> |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Librarian</b>            |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>School</b>  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |   |  |   |  |  |  |   |  |
| 13a. STATE<br><b>Maryland</b>   |  | 13b. COUNTY   |  | 13c. CITY OR TOWN<br><b>Baltimore</b>   |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>23 Hamill Court</b>   |  |
| 14 FATHER'S NAME FIRST MIDDLE LAST<br><b>Neal Alred</b>   |  |   |  |   | 15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>Nell Hubbard</b>   |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br><b>No</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>579-48-9922</b>  |  | 17 INFORMANT ADDRESS<br><b>Miss Mary I. Stephens Same</b>   |  |  |  |   |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))   |  |   |  |   |  |  |  |   |  |
| PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiac failure</b><br><b>514-</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>Pulmonary edema</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost<br>DUE TO, OR AS A CONSEQUENCE OF (c)   |  |   |  |   |  |  |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)  |  |   |  |   |  |  |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>                       |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |   |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>12/15/79</b> to <b>12/23</b> 19 <b>79</b> , that (I) (we) lost saw the deceased alive on <b>12/22</b> 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |   |  |   |  |  |  |   |  |
| 22b. SIGNATURE<br><b>Gabaltoni</b>  |  | DEGREE<br><b>MD</b>   |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>              |  |  |  | 22c. DATE SIGNED<br><b>12/23/79</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>GABALTONI</b>   |  | 22e. ADDRESS<br><b>SINAI HOSPITAL, GREENSPRING MD.</b>  |  |   |  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>12/27/79</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Glenwood</b>   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><b>District of Columbia</b>                       |  |   |  |
| 24 FUNERAL DIRECTOR NAME<br><b>Mitchell-Wiedefeld Home, Inc.</b>  |  | ADDRESS<br><b>6500 York Rd. Balto., Md.</b>   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>DEC 28 1979</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>   |  |   |  |



FOOTING      DISTANCE      INCHES      GRADE

STATION      GRADE      DISTANCE      GRADE

STATION      GRADE      DISTANCE      GRADE

STATION      GRADE      DISTANCE      GRADE

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |   |   |   |  |  |  |  |  |
|---|--|--|---|---|---|--|--|--|--|--|
| 1. FOR STATE REGISTRAR  |  | REG. NO. 7 9 3 0 6 6 6   |   |   |   |  |  |  |  |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>ASHLEY STETTLER  |  |  |   |   | 2a. DATE OF DEATH MONTH DAY YEAR<br>12 27 79                          |  |  | 2b. HOUR<br>4:10A.M.   |  |  |
| 3. SEX<br>FEMALE  |  | 4. RACE<br>WHITE   |   | 5. DATE OF BIRTH MONTH DAY YEAR<br>6 20 79  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>YRS. 06 07  |  | IF UNDER 1 YEAR<br>IF UNDER 24 HRS.  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>MARYLAND   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD.                           |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE CITY   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>UNIVERSITY OF MARYLAND |   |   |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                        |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>STATE   |  |  | 13b. COUNTY   |   | 13c. CITY OR TOWN   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 13e. STREET ADDRESS                          |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>ANTHONY MICHAEL STETTLER   |  |  |   |   | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>SUSAN LYNN STRAUSBURGER |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)   |  |  | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)                |   | 17. INFORMANT ADDRESS   |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) 7483 CARDIO PULMONARY ARREST<br>DUE TO, OR AS A CONSEQUENCE OF (b) SEVERE BRONCHO PULMONARY DYSPLASIA<br>DUE TO, OR AS A CONSEQUENCE OF (c) PREMATUREITY AND HYALINE MEMBRANES         |  |  |   |   |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br>NO WEIGHT GAIN SINCE BIRTH; S/P PDA  |  |  |   |   |   |  |  |  |  |  |
| 19a. DATE OF OPERATION  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                    |   |   | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)       |  |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   |   | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                       |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 10-23, 1979, to 12-27, 1979, that (I) (we) last saw the deceased alive on 4:10 AM 12-27-79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |   |   |   |  |  |  |  |  |
| 22b. SIGNATURE<br>Michael M. Hall   |  |  |   |   | DEGREE  |  | 22c. DATE SIGNED<br>12-27-79   |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>MICHAEL MSALL  |  |  |   |   | 22e. ADDRESS<br>UNIVERSITY OF MD HOSP / PEDIATRICS                    |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> HOUSE STAFF <input checked="" type="checkbox"/> PHYSICIAN |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>CREMATION  |  |  | 23b. DATE<br>1/10/80  |   | 23c. NAME OF CEMETERY OR CREMATORY                                    |  | 23d. LOCATION CITY OR TOWN COUNTY STATE  |  |  |  |
| 24. FUNERAL DIRECTOR NAME<br>Anatomy Board  |  |  |   |   | 25a. DATE REC'D. BY REGISTRAR<br>JAN 16 1980                          |  | 25b. REGISTRAR'S SIGNATURE<br>Anthony McCreedy   |  |  |  |



CHIT LEMBO

2022 COLLECTOR 4/13/22

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 60M 1/75  
(VRA 15(4))

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

79 30667

|  |  |   |  |  |  |   |  |
|--|--|---|--|--|--|---|--|
| 1. FOR STATE REGISTRAR   |  | 1. DECEASED NAME (TYPE OR PRINT) <b>JOHN HOLLAND STEUERNAGLE, JR.</b>   |  | 2a. DATE OF DEATH MONTH <b>12</b> DAY <b>17</b> YEAR <b>79</b>   |  | 2b. HOUR <b>1255AM</b>  |  |
| 3. SEX <b>Male</b>   |  | 4. RACE <b>White</b>  |  | 5. DATE OF BIRTH MONTH <b>9</b> DAY <b>18</b> YEAR <b>18</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY) <b>61</b>   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>  |  | 7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>Balto. City</b>   |  |
| 10. CITY OR TOWN OF DEATH <b>Balto.</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Balto. City Hosp.</b>   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Maintenance</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |
| 13a. STATE <b>Maryland</b>   |  | 13b. COUNTY <b>-</b>  |  | 13c. CITY OR TOWN <b>Baltimore</b>   |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |  |
| 14. FATHER'S NAME FIRST <b>John</b> MIDDLE <b>H.</b> LAST <b>Steuernagle</b>   |  | 15. MOTHER'S MAIDEN NAME FIRST <b>Sr. Agnes</b> MIDDLE <b>Willis</b>  |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>  |  | 16b. SOCIAL SECURITY NO. <b>217-07-3087</b>   |  |
| 17. INFORMANT ADDRESS <b>same</b>  |  | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiopulmonary arrest</b> (b) <b>Probable Myocardial Infarct</b> (c) <b>410-</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. |  |  |  |   |  |
| PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |   |  |  |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |   |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost <u>saw</u> the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. |  |   |  |  |  |   |  |
| 22b. SIGNATURE <b>G. Weiner</b>  |  | DEGREE <b>MD</b>  |  | 22c. DATE SIGNED <b>12/17/79</b>   |  | 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>G. WEINER</b>  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>  |  | 23b. DATE <b>18 Dec 79</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY <b>Sacred Heart Cem.</b>  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore Maryland</b>   |  |
| 24. FUNERAL DIRECTOR <b>Schlimmek Funeral Home, Inc.</b>   |  | ADDRESS <b>3331 Brehms Lane Balto., Md. 21213</b>   |  | 25. DATE REC'D. BY REGISTRAR <b>DEC 18 1979</b>  |  | 26. SIGNATURE <b>[Signature]</b>  |  |

MEDICAL CERTIFICATION

99

BP

0102



Oct 1953

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  |   |  |   |  |  |  |
|--|--|--|--|---|--|---|--|--|--|
| 1. FOR STATE REGISTRAR   |  | 7 9 3 0 6 6 8<br>REG. NO.  |  | 1. DECEASED NAME (TYPE OR PRINT)  |  | 2a. DATE OF DEATH   |  | 2b. HOUR   |  |
| FIRST  |  | MIDDLE   |  | LAST  |  | MONTH   |  | DAY  |  |
| Arabella   |  | Stevens  |  |   |  | 12-30-79  |  | 9:30A M  |  |
| 3 SEX  |  | 4 RACE   |  | 5 DATE OF BIRTH   |  | 6 AGE (IN YEARS LAST BIRTHDAY)                                      |  | 7 IF UNDER 1 YEAR  |  |
| Female   |  | Caucasian  |  | Nov. 14, 1892   |  | 87 YRS.   |  | MONTHS   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH                                 |  | 10b. KIND OF BUSINESS OR INDUSTRY                        |  |
| Maryland   |  | USA  |  |   |  | BALTIMORE CITY MD.  |  | Own Home   |  |
| 10 CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)   |  | 12b. KIND OF BUSINESS OR INDUSTRY                                   |  |  |  |
| CITY   |  | ST. AGNES  |  | Housewife   |  |   |  |  |  |
| 13a. STATE   |  | 13b. COUNTY  |  | 13c. CITY OR TOWN   |  | 13d. INSIDE CITY LIMITS?  |  | 13e. STREET ADDRESS                                      |  |
| Md.  |  | Howard   |  | Elkridge  |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 6374 Euclid Avenue                                       |  |
| 14 FATHER'S NAME   |  | 15. MOTHER'S MAIDEN NAME   |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)   |  | 16b. SOCIAL SECURITY NO.  |  | 17 INFORMANT   |  |
| Charles  |  | Sarah  |  | No  |  | 216-07-3335   |  | D, Flora E. James, daughter, same as 13                  |  |
| 18a. FATHER'S NAME   |  | 18b. MOTHER'S MAIDEN NAME  |  | 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                    |  | 19c. AUTOPSY?  |  |
| Charles  |  | Sarah  |  | 11/12/79  |  | complete colonic obstruction  |  | YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 19c. AUTOPSY?   |  | 19d. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?      |  |  |  |
| 11/12/79   |  | complete colonic obstruction   |  | YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | YES <input type="checkbox"/> NO <input type="checkbox"/>            |  |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 20b. TIME OF INJURY  |  | 20c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  | 20d. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?      |  |  |  |
|  |  | P.M.   |  | 19  |  | YES <input type="checkbox"/> NO <input type="checkbox"/>            |  |  |  |
| 21a. INJURY OCCURRED   |  | 21b. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  | 21c. LOCATION   |  | 21d. CITY OR TOWN   |  | 21e. COUNTY  |  |
| WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |  |  | STREET  |  | CITY OR TOWN  |  | COUNTY   |  |
| 22a. I certify that (A) this hospital attended the deceased from 11/14/79 to 12/30/79, that (I) (we) last saw the deceased alive on 12/30/79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we did not view the body after death) |  | 22b. SIGNATURE   |  | 22c. ADDRESS  |  | 22d. DATE SIGNED  |  |  |  |
|  |  | G.X. APOSTOLIDES   |  | St Agnes Hosp.  |  | 12/30/79  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY  |  | 23d. LOCATION   |  | 23e. COUNTY  |  |
| Burial   |  | 2 Jan. 80  |  | Loudon Park   |  | Baltimore, Balto., Md.  |  | BALTO.   |  |
| 24 FUNERAL DIRECTOR  |  | 24a. NAME  |  | 24b. ADDRESS  |  | 24c. DATE REC'D. BY REGISTRAR                                       |  | 24d. REGISTRAR'S SIGNATURE                               |  |
| James S. Kirkley   |  | Glen Burnie, Md.   |  |   |  | JAN 3 1980  |  | Fitzroy Kelly  |  |



James C. ...  
Baltimore City  
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*Handwritten:*  
Co. of ...  
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

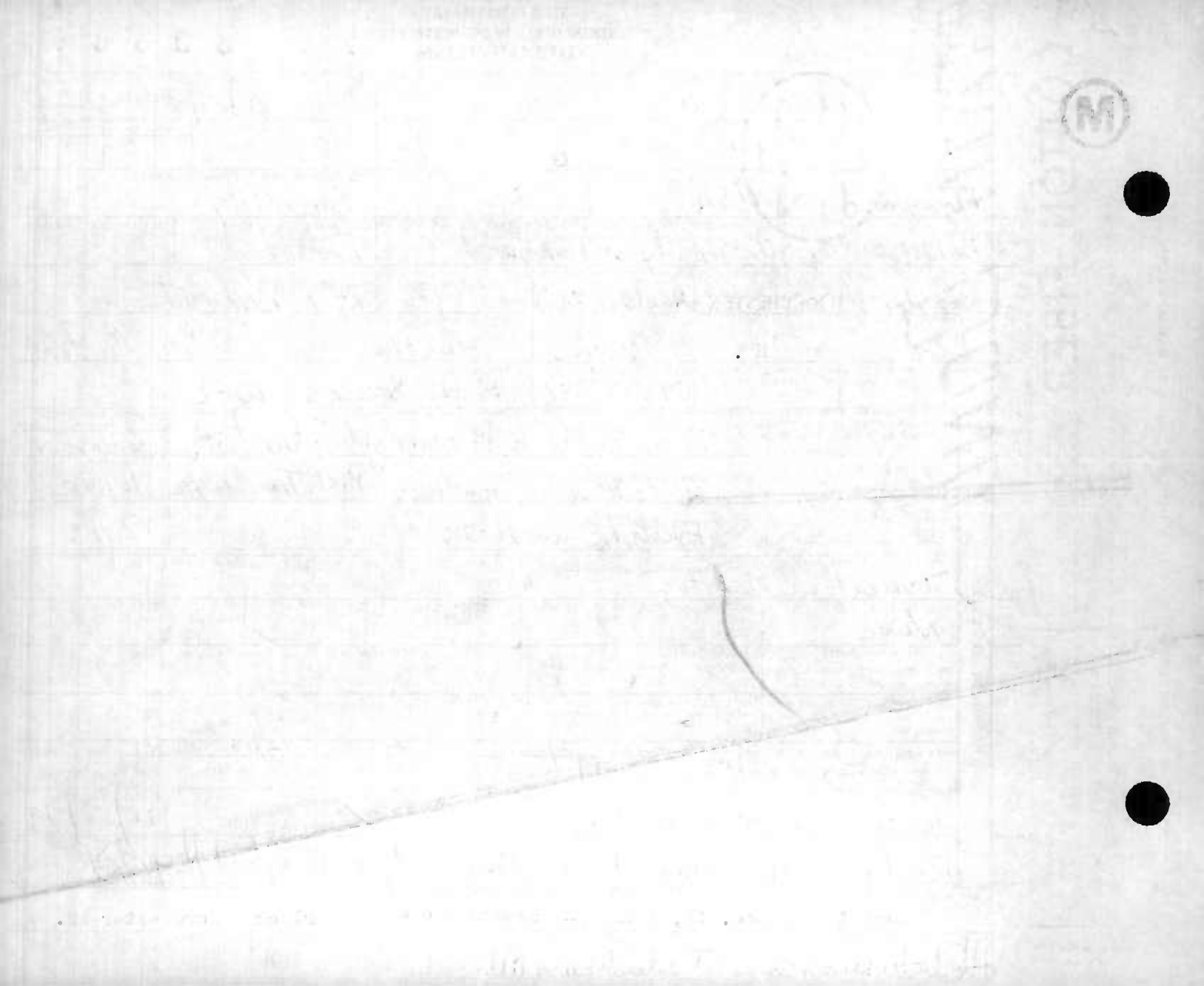
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  |  |   |  |                                   |   |  |  |
|---|--|---|--|--|---|--|-----------------------------------|---|--|--|
| 1. DECEASED NAME (TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>Harold H Steevens  |  |   |  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br>12/27/79                |  | 2b. HOUR<br>2:50 P.M.             |   |  |  |
| 3 SEX<br>M  |  | 4 RACE<br>W   |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>01 12 22  |   | 6 AGE (IN YEARS LAST BIRTHDAY)<br>57   |                                   | 7. UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.   |  |  |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland  |  | 7b CITIZEN OF WHAT COUNTRY?<br>USA  |  | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9 BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.                            |                                   |   |  |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore City   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>University of Maryland |  |  |   | 12a USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>HARDER            |                                   | 12b. KIND OF BUSINESS OR INDUSTRY   |  |  |
| 13a. STATE<br>Maryland  |  |   |  |  | 13b. COUNTY<br>DORCHESTER                                   |  | 13c. CITY OR TOWN<br>Harlock 2143 |   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>Lee H. Steevens  |  |   |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Martha Boston |  |                                   |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>098 16 4248  |  | 17 INFORMANT ADDRESS<br>Ruth Steevens wife   |   |  |                                   |   |  |  |
| 18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) 5712 Acute Infarction Myocardial Infarction<br>DUE TO, OR AS A CONSEQUENCE OF (b) Acute Hepatic Failure Post Transfusion<br>DUE TO, OR AS A CONSEQUENCE OF (c) Alcoholic Cirrhosis<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>6 hrs<br>6 wks<br>2 yrs |  |   |  |  |   |  |                                   | PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1.<br>Diabetes Mellitus |  |  |
| 19a. DATE OF OPERATION<br>None  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                            |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |   |  |                                   |   |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |   |  |                                   |   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 12/26, 1979, to 12/27, 1979, that (I) (we) lost<br>saw the deceased alive on 12/27, 1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above. (I) (we) (did) (did not) view the body after death.  |  |   |  |  |   |  |                                   |   |  |  |
| 22b. SIGNATURE<br>Richard A. Baum MD  |  |   |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>       |   |  |                                   | 22c. DATE SIGNED<br>12/27/79  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Richard A. Baum MD   |  |   |  | 22e. ADDRESS<br>University of Maryland Hospital  |   |  |                                   |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial  |  | 23b. DATE<br>Dec. 31, 1979  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>VA Eastern Shore   |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Hurlock Dorchester Md.                 |                                   |   |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>H. Williams   |  |   |  | ADDRESS<br>Federalburg Md.   |   | 25a. DATE REC'D. BY REGISTRAR<br>JAN 4 1980  |                                   | 25b. REGISTRAR'S SIGNATURE<br>[Signature]   |  |  |



RECEIVED  
FEBRUARY 1964  
MILITARY



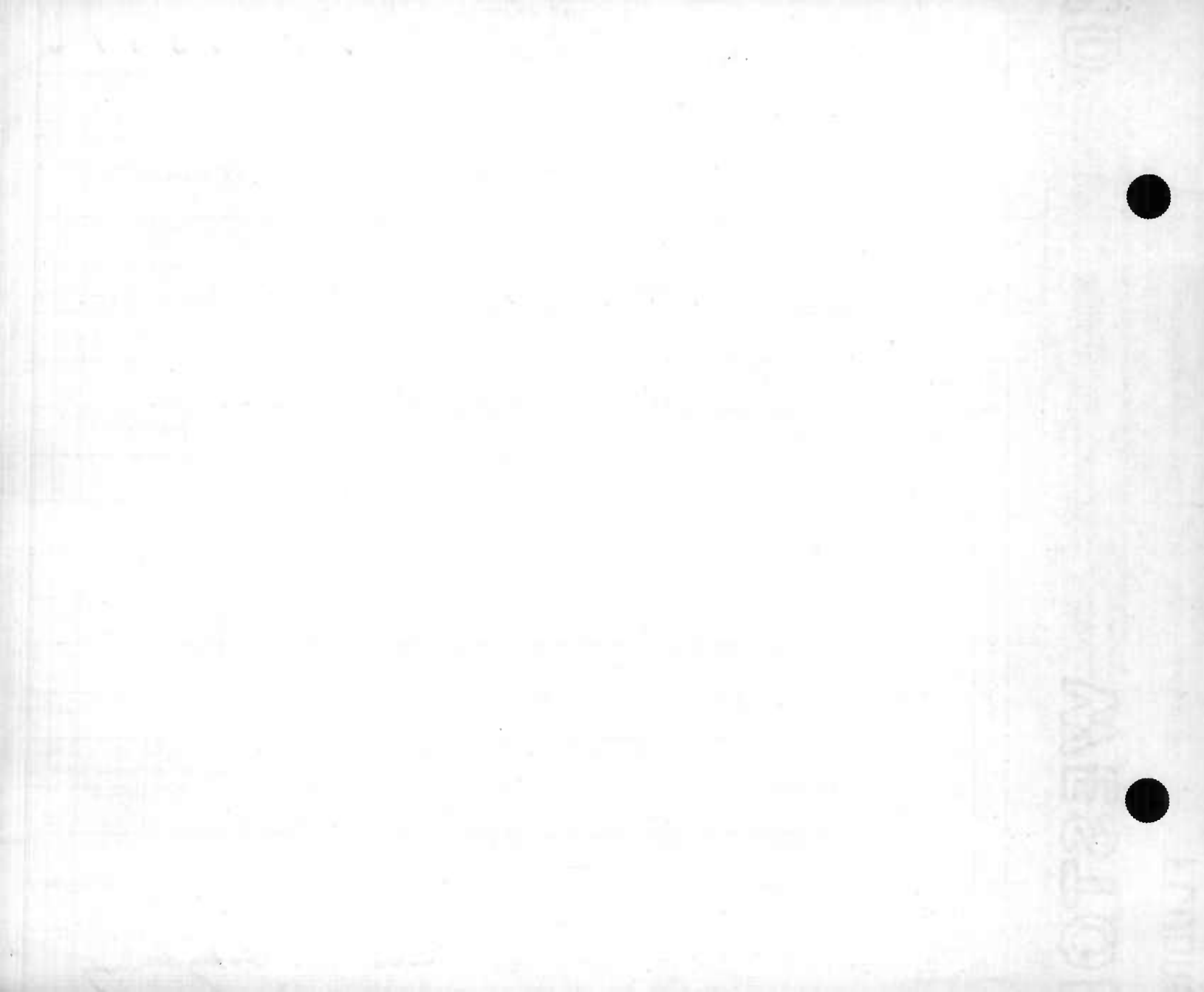


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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  |   |  |   |  |  |  |
|---|--|--|--|---|--|---|--|--|--|
| 1. FOR STATE REGISTRAR<br>(Darnetta)  |  | 7 9 3 0 6 7 0<br>REG. NO.  |  |   |  |   |  |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) <u>STITH B G / <del>W</del></u>   |  |  |  | 2a. DATE OF DEATH<br>MONTH <u>12</u> DAY <u>27</u> YEAR <u>79</u>   |  |   |  | 2b. HOUR<br><u>1120</u> P. M.  |  |
| 3. SEX<br><u>♀</u>  |  | 4. RACE<br><u>B</u>  |  | 5. DATE OF BIRTH<br>MONTH <u>12</u> DAY <u>27</u> YEAR <u>79</u>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>YRS. MONTHS <u>0</u> DAYS <u>0</u>                           |  | 7. IF UNDER 1 YEAR<br>HOURS <u>0</u> MIN. <u>0</u>   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><u>md</u>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><u>US</u>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><u>Baltimore City</u> MD.                               |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><u>Baltimore</u>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><u>Simon Hosp</u> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)                                |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| 13a. STATE<br><u>Maryland</u>   |  | 13b. COUNTY<br><u>Baltimore</u>  |  | 13c. CITY OR TOWN<br><u>Baltimore</u>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><u>905 Penna. Ave. Apt. 3A</u>  |  |
| 14. FATHER'S NAME<br>FIRST <u>Wayne</u> MIDDLE <u>STITH</u> LAST <u>STITH</u>   |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST <u>Nancy</u> MIDDLE <u>Coffield</u> LAST <u>Coffield</u>  |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><u>N/A</u>  |  | 16b. SOCIAL SECURITY NO.<br><u>N/A</u>   |  | 17. INFORMANT<br>FIRST <u>STITH</u> ADDRESS<br><u>Wayne Smith 905 Penna. Ave.</u>   |  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART 1. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <u>Cardiac arrest</u><br><u>7708</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) <u>respiratory distress &amp; ? intracranial hemorrhage</u><br>(c) <u>prematurity</u>    |  |  |  |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |  |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                       |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><u>P.M.</u> <u>19</u>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>12/27</u> , 19 <u>79</u> , to <u>12/27</u> , 19 <u>79</u> , that (I) (we) lost saw the deceased alive on <u>12/27</u> , 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |   |  |   |  |  |  |
| 22b. SIGNATURE<br><u>Ardele M. Galante, M.D.</u>  |  |  |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>        |  |   |  | 22c. DATE SIGNED<br><u>12/28/79</u>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><u>ARDELE M. GALANTE, M.D.</u>   |  |  |  | 22e. ADDRESS<br><u>6059 Majors Ln Columbia, Md</u>  |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><u>Burial</u>   |  | 23b. DATE<br><u>1-2-80</u>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><u>WESTERN STAR CEM.</u>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><u>CATONSVILLE, MD.</u>                           |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><u>Wm. C. March F/H</u>   |  |  |  | ADDRESS<br><u>1101 E. North Ave.</u>  |  | 25a. DATE REC'D. BY REGISTRAR<br><u>DEC 31 1979</u>   |  | 25b. REGISTRAR'S SIGNATURE<br><u>Hester</u>  |  |



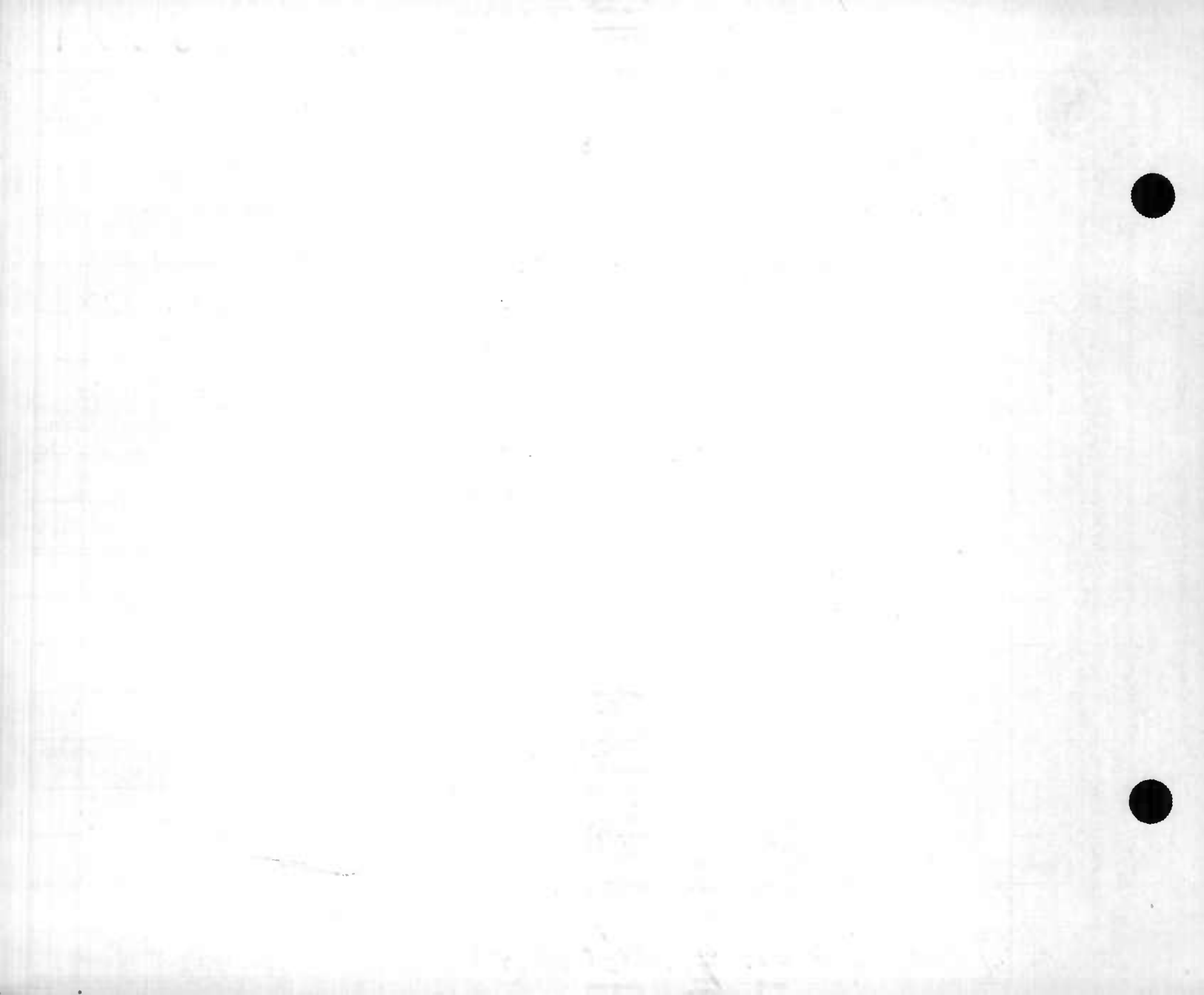
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  | 7 9 3 0 6 7 1<br>REG. NO.  |  |
|--|--|---|--|--|--|
| 1. FOR STATE REGISTRAR   |  | 1. DECEASED NAME (TYPE OR PRINT)                                    |  | 2a. DATE OF DEATH MONTH DAY YEAR   |  |
|  |  | FIRST MIDDLE LAST   |  | Dec. 20, 1979  |  |
| 3. SEX   |  | 4. RACE   |  | 2b. HOUR   |  |
| FEMALE   |  | Black   |  | 2:08 M   |  |
| 5. DATE OF BIRTH   |  | 6. AGE (IN YEARS LAST BIRTHDAY)                                     |  | 7. IF UNDER 1 YEAR   |  |
| MONTH DAY YEAR   |  | 63 YRS  |  | MONTHS DAYS HOURS MIN  |  |
| 10. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION             |  | 9. BALTIMORE CITY OR COUNTY OF DEATH   |  |
| Baltimore  |  | Key Circle Hospice  |  | Baltimore City MD.   |  |
| 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |  | 12b. KIND OF BUSINESS OR INDUSTRY                                   |  |  |  |
| None   |  | None  |  |  |  |
| 13a. STATE   |  | 13b. COUNTY   |  | 13c. CITY OR TOWN  |  |
| md.  |  |   |  | Balto.   |  |
| 14. FATHER'S NAME  |  | 15. MOTHER'S MAIDEN NAME  |  | 13d. STREET ADDRESS  |  |
| FIRST MIDDLE LAST  |  | FIRST MIDDLE LAST   |  | 828 N. Eutaw Place   |  |
| Unknown  |  | Unknown   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)  |  | 16b. SOCIAL SECURITY NO.  |  | 17. INFORMANT ADDRESS  |  |
| No   |  | 250-34-9871   |  | Virginia Mai DuBritton, R.N. - Director  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                   |  |
| IMMEDIATE CAUSE (a):   |  |   |  | Cerebro Vascular Accidents several months                                      |  |
| DUE TO, OR AS A CONSEQUENCE OF   |  |   |  |  |  |
| (b):   |  |   |  | Arteriosclerosis   |  |
| DUE TO, OR AS A CONSEQUENCE OF   |  |   |  |  |  |
| (c):   |  |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a):   |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                    |  | 20a. AUTOPSY?  |  |
|  |  |   |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR                        |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |
|  |  | P.M. 19   |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                 |  |
|  |  |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 3-7-79 to 12-20-79, that (I) (we) lost saw the deceased alive on 12-20-79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. |  |   |  |  |  |
| 22b. SIGNATURE   |  | DEGREE  |  | 22c. DATE SIGNED   |  |
| E. Ellsworth Cook  |  | M.D.  |  | 12-20-79   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  | 22e. ADDRESS  |  |  |  |
| E. Ellsworth Cook  |  | 2431 Maryland   |  | Baltimore, Md. 21218   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |  | 23b. DATE   |  | 23c. NAME OF CEMETERY OR CREMATORY   |  |
| Removal  |  | 12/20/79  |  |  |  |
| 23d. LOCATION CITY OR TOWN   |  | COUNTY  |  | STATE  |  |
|  |  |   |  |  |  |
| 24. FUNERAL DIRECTOR NAME  |  | 25a. DATE REC'D. BY REGISTRAR                                       |  | 25b. REGISTRAR'S SIGNATURE   |  |
| Funeral Home of Dr. L. K. K. K.  |  | DEC 24 1979   |  | L. K. K. K.  |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  |  |   |  |   |   |  |
|--|--|---|--|--|---|--|---|---|--|
| 1. FOR STATE REGISTRAR <b>BERNARD EDWIN STODDART</b> REG. NO. <b>79 30672</b>  |  |   |  |  |   |  |   |   |  |
| 1. DECEASED NAME (TYPE OR PRINT) <b>BERNARD EDWIN STODDART</b>   |  |   |  |  | 2. DATE OF DEATH MONTH <b>December</b> DAY <b>20</b> YEAR <b>79</b>   |  | 2b. HOUR <b>6:28 A.M.</b>                     |   |  |
| 3. SEX <b>Male</b>   |  | 4. RACE <b>White</b>  |  | 5. DATE OF BIRTH MONTH <b>August</b> DAY <b>18</b> YEAR <b>1911</b>  |   | 6. AGE (IN YEARS LAST BIRTHDAY) <b>68</b>  |   | 7. IF UNDER 1 YEAR MONTHS <b></b> DAYS <b></b>  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Illinois</b>  |  | 7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.                               |   |   |  |
| 10. CITY OR TOWN OF DEATH <b>Baltimore</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Deaton Medical Center</b> |  |  |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Machinist</b>               |   | 12b. KIND OF BUSINESS OR INDUSTRY <b>Allis Chalmers</b>   |  |
| 13a. STATE <b>Maryland</b>   |  | 13b. COUNTY <b>AA</b>   |  | 13c. CITY OR TOWN <b>Severn</b>  |   | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 13e. STREET ADDRESS <b>Bells Trailer Park Lot 8</b>   |  |
| 14. FATHER'S NAME FIRST <b>Edwin</b> MIDDLE <b></b> LAST <b>Stoddart</b>   |  |   |  |  | 15. MOTHER'S MAIDEN NAME FIRST <b>Clara</b> MIDDLE <b></b> LAST <b>Philip</b>   |  |   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>  |  | 16b. SOCIAL SECURITY NO. <b>030.03.5875</b>   |  | 17. INFORMANT ADDRESS <b>Same as 13</b><br><b>Mrs. Katherine A. Stoddart (wife)</b>  |   |  |   |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line (a), (b), and (c))<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Respiratory Arrest</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>Pneumonia</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>Chronic Lymphatic leukemia</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>3041</b> |  |   |  |  |   |  |   |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>Chronic Lymphatic leukemia</b>  |  |   |  |  |   |  |   |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  |   | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |   |  |   |   |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |   |  |   |   |  |
| 22. I certify that (I) (this hospital) attended the deceased from <b>12/18</b> , 19 <b>79</b> , to <b>12/20</b> , 19 <b>79</b> , that (I) (we) lost saw the deceased alive on <b>12/20</b> , 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                               |  |   |  |  |   |  |   |   |  |
| 23a. SIGNATURE <b>Dr. Charles Brown</b> DEGREE <b>MD</b>   |  |   |  |  | 23b. ATTENDING MEDICAL STAFF PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/> |  |   | 23c. DATE SIGNED <b>12-20-79</b>  |  |
| 24a. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Dr. Charles Brown</b>   |  |   |  |  | 24b. ADDRESS <b>611 D. Charles Street</b>   |  |   |   |  |
| 25a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>  |  | 25b. DATE <b>Dec. 22, 79</b>  |  | 25c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cemetery</b>  |   | 25d. LOCATION CITY OR TOWN COUNTY STATE <b>Brooklyn Park-AA Md.</b>                          |   |   |  |
| 26. FUNERAL DIRECTOR NAME <b>Singleton Funeral Home, Glen Burnie, Md.</b> ADDRESS <b></b>  |  |   |  |  | 26a. DATE REC'D. BY REGISTRAR <b>DEC 21 1979</b>  |  | 26b. REGISTRAR'S SIGNATURE <b>[Signature]</b> |   |  |

STANDARD 20 7A 24

|                |       |     |
|----------------|-------|-----|
| Illinois       | White | 111 |
| Massachusetts  | White | 111 |
| Michigan       | White | 111 |
| Minnesota      | White | 111 |
| Mississippi    | White | 111 |
| Missouri       | White | 111 |
| Montana        | White | 111 |
| Nebraska       | White | 111 |
| Nevada         | White | 111 |
| New Hampshire  | White | 111 |
| New Jersey     | White | 111 |
| New Mexico     | White | 111 |
| New York       | White | 111 |
| North Carolina | White | 111 |
| North Dakota   | White | 111 |
| Ohio           | White | 111 |
| Oklahoma       | White | 111 |
| Oregon         | White | 111 |
| Pennsylvania   | White | 111 |
| Rhode Island   | White | 111 |
| South Carolina | White | 111 |
| South Dakota   | White | 111 |
| Tennessee      | White | 111 |
| Texas          | White | 111 |
| Vermont        | White | 111 |
| Virginia       | White | 111 |
| Washington     | White | 111 |
| West Virginia  | White | 111 |
| Wisconsin      | White | 111 |
| Wyoming        | White | 111 |

Handwritten notes and signatures, including "James H. [illegible]" and "J. [illegible]".

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## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  | REG. NO. 79 30673   |  |  |  |
|---|--|--|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>MARY Elizabeth STONER</b>  |  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR <b>12-17-79</b>  |  |  |  |
| 3. SEX <b>female</b>  |  | 4. RACE <b>white</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR <b>Jan. 6, 1893</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY) <b>86</b> YRS.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>   |  | 7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.  |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>ST. AGNES HOSPITAL</b> |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>St. Agnes Hosp.</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Housemother</b>  |  |
| 13a. STATE <b>Maryland</b>  |  |  |  | 13b. COUNTY <b>Howard</b>   |  | 13c. CITY OR TOWN <b>Ellicott City</b>   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST <b>Charles Cavey</b>   |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST <b>MARY ANN King</b>  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>no</b>  |  |  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES) <b>218 05 2042 A</b>  |  | 17. INFORMANT<br><b>Dewey J. Stoner</b>  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Acute myocardial infarct</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) _____<br>DUE TO, OR AS A CONSEQUENCE OF (c) _____  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) _____   |  |  |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>12/14/79</b> to <b>12/17/79</b> , that (I) (we) last saw the deceased alive on <b>12/17/79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |   |  |  |  |
| 22b. SIGNATURE<br><b>C. Nyunt</b>   |  |  |  | DEGREE  |  | 22c. DATE SIGNED<br><b>12/17/79</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>KYAW NYUNT</b>  |  |  |  | 22e. ADDRESS<br><b>900 CATON AVE. BALTIMORE, MD. 21229</b>  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY) <b>burial</b>  |  | 23b. DATE<br><b>12/20/79</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Good Shepherd Cem.</b>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Ellicott City, Howard, Maryland</b>                                       |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>SLACK Funeral Home, Ellicott City, Maryland 21043</b>  |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>DEC 26 1979</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>Robert A. Bundy</b>   |  |

BP \_\_\_\_\_

BALTIMORE CITY

ST. AGNES HOSPITAL

BALTIMORE

MARY ANN

Admission to St. Agnes Hospital

RECEIVED BY THE HOSPITAL

900 CATON AVE. BALTIMORE, MD. 21229

KVAH HUNTER



1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

7930674

|   |  |   |  |   |   |  |   |  |   |  |
|---|--|---|--|---|---|--|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Lydia M. STRAUB</b>   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>12 - 1 - 79</b>            |   |   | 2b. HOUR<br><b>8:10 AM</b>   |   |  |   |  |
| 3. SEX<br><b>Female</b>   |  | 4. RACE<br><b>White</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Sept. 2, 1906</b>  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>73</b> YRS.                                    |   | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.  |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE (CITY)</b> MD.                  |   |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>UNION MEMORIAL HOSPITAL</b> |  |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Homemaker</b> |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Own Home</b>   |   |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>Maryland</b>  |  |   | 13b. COUNTY<br><b>Baltimore</b>                                      |   | 13c. CITY OR TOWN<br><b>Baltimore</b>                 |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>3917 Juniper Road</b> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Sebastian Grabenstein</b>  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Anna M. Luke</b> |   |   |  |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>   |  |   | 16b. SOCIAL SECURITY NO.<br><b>215 58 3925</b>                       |   | 17. INFORMANT<br>ADDRESS<br><b>Mr. Erik K. Straub</b> |  |   |  | Same  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1 DEATH WAS CAUSED BY<br><b>1889 IMMEDIATE CAUSE (a) CARDIORESPIRATORY FAILURE</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>DISEMINATED CARCINOMA</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>SQUAMOUS CARCINOMA OF THE PELVIS</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br><b>3 MONTH</b> |  |   |  |   |   |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>2 HOURS</b>   |   |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |   |  |   |   |  |   |  |   |  |
| 19a. DATE OF OPERATION<br><b>11/20/79</b>   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>SQUAMOUS CARCINOMA OF THE BLADDER<br/>FECAL AND URINARY FISTULAS</b>                 |  |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |   |  |   |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |  |   |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>10-16</b> 19 <b>79</b> , to <b>12-1</b> 19 <b>79</b> , that (I) (we) lost<br>saw the deceased alive on <b>12-1</b> 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above. (I) (we) (did) (did not) view the body after death.   |  |   |  |   |   |  |   |  |   |  |
| 27b. SIGNATURE<br><i>Chas Puyos</i>   |  |   |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>        |   |  |   | 22c. DATE SIGNED<br><b>12-1-79</b>   |   |  |
| 27a. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>CARLOS A. ABTE</b>  |  |   |  | 22e. ADDRESS<br><b>UNION MEMORIAL HOSPITAL Balto., Md.</b>  |   |  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Cremation</b>  |  | 23b. DATE<br><b>12/4/79</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Greenmount</b>   |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore, Md.</b>                  |   |  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Henry W. Jenkins &amp; Sons Co.</b>  |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>DEC 3 1979</b>  |   | 25b. REGISTRAR'S SIGNATURE<br><i>Henry W. Jenkins</i>                                |   |  |   |  |
| 4905 York Road Balto., Md. 21212  |  |   |  |   |   |  |   |  |   |  |

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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NTW 5

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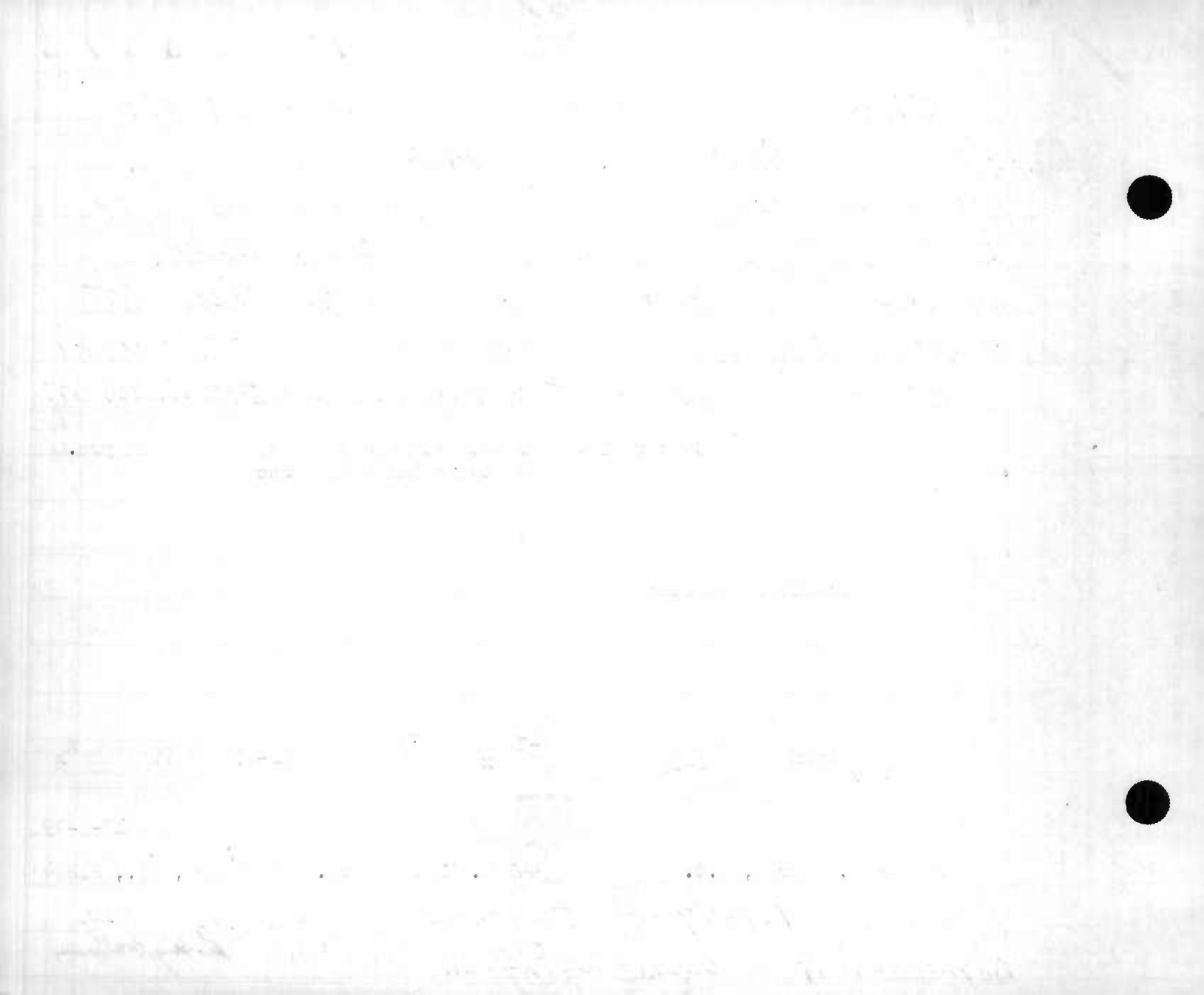
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 7 days of the death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of one.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  | 7 9 3 0 6 7 5<br>REG. NO.   |  |   |  |
|--|--|---|--|---|--|---|--|
| 1. FOR STATE REGISTRAR   |  |   |  | 2a. DATE OF DEATH MONTH DAY YEAR  |  |   |  |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br><b>CLARA STREMPEK</b>  |  |   |  | 2b. HOUR<br>M   |  |   |  |
| 3 SEX<br><b>FEMALE</b>   |  | 4 RACE<br><b>WHITE</b>  |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>SEPT. 17 1912</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY) YRS.<br><b>67</b>   |  |
| 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MARYLAND</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.   |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>3128 DILLON ST.</b>  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>HOME MAKER</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |
| 13a. STATE<br><b>MARYLAND</b>  |  | 13b. COUNTY<br><b>BALTIMORE</b>   |  | 13c. CITY OR TOWN<br><b>BALTIMORE</b>   |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>MARTIN MROZINSKI</b>   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>CATHERINE KOCZOROWSKI</b>  |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br><b>NO</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>213 03 6925</b>  |  |
| 17. INFORMANT ADDRESS<br><b>MR. HENRY STREMPEK 3128 DILLON ST.</b>   |  | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cancer of the breast with generalized metastasis including bone</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:<br>(b) _____<br>(c) _____<br>DUE TO, OR AS A CONSEQUENCE OF |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>2 1/2 yrs.</b>   |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).<br><b>Diabetes mellitus</b>   |  |   |  |   |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><b>11-17 19 79</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>8-21 19 73</b> , to <b>11-17 19 79</b> , that (I) (we) lost saw the deceased alive on <b>11-17 19 79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we had) (I did not) view the body after death. |  |   |  |   |  |   |  |
| 22b. SIGNATURE<br><b>Melito M. Torres</b>  |  | DEGREE  |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                             |  | 22c. DATE SIGNED<br><b>12-3-79</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Melito M. Torres, M.D.</b>   |  | 22e. ADDRESS<br><b>441 S. Ellwood Ave. Baltimore, Md., 21224</b>  |  | 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>BURIAL</b>  |  | 23b. DATE<br><b>12/5/79</b>   |  |
| 23c. NAME OF CEMETERY OR CREMATORY<br><b>ST. STANISLAUS</b>  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><b>BALTIMORE MD.</b>   |  | 24. FUNERAL DIRECTOR NAME<br><b>RAYMOND L. KACZOROWSKI</b>  |  | 25. DATE REC'D. BY REGISTRAR<br><b>DEC 4 1979</b>   |  |
| 24. FUNERAL DIRECTOR ADDRESS<br><b>2525 FLEET ST</b>   |  | 25. REGISTRAR'S SIGNATURE<br><b>Anthony McCreedy</b>  |  | 26. REGISTRAR'S NAME<br><b>Anthony McCreedy</b>   |  |   |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  |   |  |  |  |  |  | 79 30676<br>REG. NO.                         |  |
|---|--|--|--|---|--|--|--|--|--|--|--|
| 1. FOR STATE REGISTRAR  |  | 1. DECEASED NAME (TYPE OR PRINT)<br>HERMAN, STRUCK   |  |   |  | 2a. DATE OF DEATH<br>12/23/79  |  | 2b. HOUR<br>4:25 AM  |  |  |  |
| 3 SEX<br>Male   |  | 4 RACE<br>White  |  | 5. DATE OF BIRTH<br>Jan. 7, 1900  |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br>79 YRS.  |  | 7 UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.   |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD.                           |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>UNION MEMORIAL HOSPITAL |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Security            |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>-   |  |  |  |
| 13a. STATE<br>Maryland  |  | 13b. CITY OR TOWN<br>Baltimore   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 13e. STREET ADDRESS<br>4351 Shamrock Ave. 21206                                      |  |  |  |  |  |
| 14. FATHER'S NAME<br>Frank Struck   |  |  |  | 15. MOTHER'S MAIDEN NAME<br>Carrie Christopher  |  |  |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>Yes   |  | 16b. SOCIAL SECURITY NO.<br>215-09-2938  |  | 17. INFORMANT ADDRESS<br>Mrs. Helen Struck, wife, same address  |  |  |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Unknown</u><br>436-<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:<br>(b) <u>CVA</u><br>(c) <u>CVA</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>DUE TO, OR AS A CONSEQUENCE OF     |  |  |  |   |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):<br><u>Anterior Myocardial Infarction</u>   |  |  |  |   |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>12/14</u> , 19 <u>79</u> , to <u>12/23</u> , 19 <u>79</u> , that (I) (we) lost saw the deceased alive on <u>12/23</u> , 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |   |  |  |  |  |  |  |  |
| 22b. SIGNATURE<br><u>D. Berliner</u>  |  |  |  | DEGREE<br><u>MD</u><br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>      |  |  |  | 22c. DATE SIGNED<br><u>12/23/79</u>  |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><u>D. Berliner</u>   |  |  |  | 22e. ADDRESS<br><u>Union Memorial Hosp</u>  |  |  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial   |  | 23b. DATE<br>Dec. 27, 79   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Holy Redeemer Cem.  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore, Maryland                    |  |  |  |  |  |
| 24. FUNERAL DIRECTOR<br><u>Samimunek Funeral Home, Inc.</u>   |  |  |  | ADDRESS<br><u>3331 Brehms Lane Balto., Md.</u>  |  | 25a. DATE REC'D. BY REGISTRAR<br><u>DEC. 28 1979</u>                                 |  | 25b. REGISTRAR'S SIGNATURE<br><u>Robert A. Brady</u>   |  |  |  |

1108

DEPT. OF AGRICULTURE  
WASHINGTON, D. C.  
BUREAU OF PLANT INDUSTRY  
M. E. L. I. O.

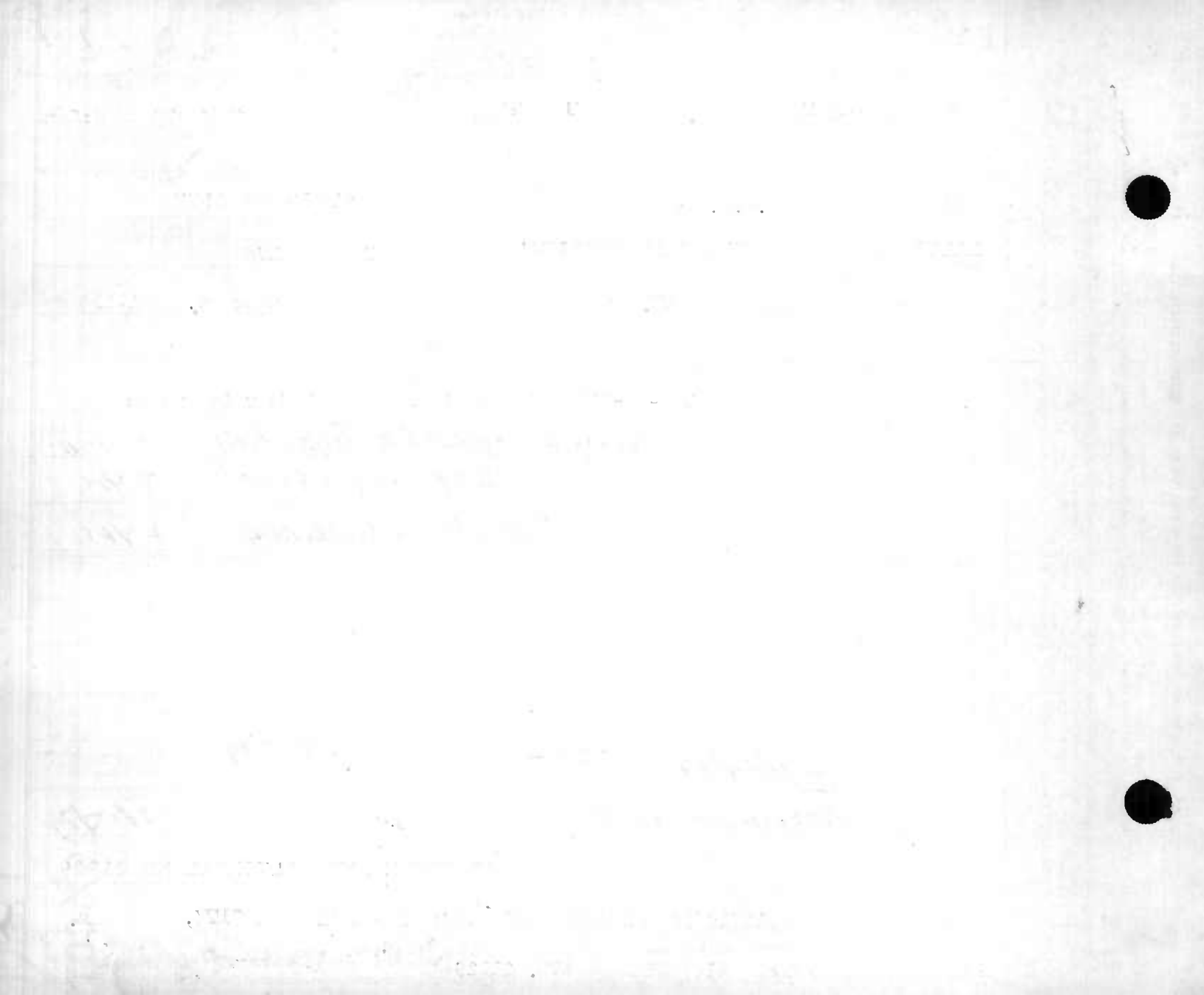


TO HOSPITAL OR ATTENDING PHYSICIAN The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |   |  |                   |  |   |  |  |
|--|--|--|---|--|-------------------|--|---|--|--|
| 1. FOR<br>STATE<br>REGISTRAR   |  |  | 7 9 3 0 6 7<br>REG. NO.   |  |                   |  |   |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  |  | FIRST MIDDLE LAST   |  |                   | 2a. DATE OF DEATH MONTH DAY YEAR   |   |  | 2b. HOUR                                     |
| ROBERT GRAHAM SULLIVAN   |  |  |   |  |                   | 12/15/79   |   |  | 8:26 AM                                      |
| 3. SEX   |  | 4. RACE  |   | 5. DATE OF BIRTH MONTH DAY YEAR  |                   | 6. AGE (IN YEARS LAST BIRTHDAY)  |   | 7. IF UNDER 1 YEAR IF UNDER 24 HRS                             |  |
| MALE   |  | WHITE  |   | 4 20 07  |                   | 72   |   | MONTHS DAYS HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  | 7b. CITIZEN OF WHAT COUNTRY?   |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                   | 9. BALTIMORE CITY OR COUNTY OF DEATH   |   |  |  |
| MARYLAND   |  | U.S.A.   |   |  |                   | BALTIMORE CITY MD.   |   |  |  |
| 10. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |   |  |                   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |   | 12b. KIND OF BUSINESS OR INDUSTRY                              |  |
| BALTIMORE  |  | ST AGNES HOSPITAL  |   |  |                   | TRUCK DRIVER   |   |  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  |  |   |  | 13a. CITY OR TOWN |  | 13b. INSIDE CITY LIMITS?  |  | 13c. STREET ADDRESS                          |
| 13a. STATE MARYLAND  |  |  |   |  | BALTIMORE         |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 2405 Herkimer St. 21230                      |
| 14. FATHER'S NAME FIRST MIDDLE LAST  |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST                          |  |                   |  |   |  |  |
| MICHAEL SULLIVAN   |  |  | LAURA COLLINS   |  |                   |  |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)  |  |  | 16b. SOCIAL SECURITY NO.  |  |                   | 17. INFORMANT ADDRESS  |   |  |  |
| NO   |  |  | 215-09-1512   |  |                   | GLORIA GUSEMAN 2802 Georgia Avenue   |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:  |  |  |   |  |                   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| IMMEDIATE CAUSE (a) <i>Massive myocardial Infarction</i>   |  |  |   |  |                   |  |   |  | 30 min.                                      |
| DUE TO, OR AS A CONSEQUENCE OF <i>coronary artery disease</i>  |  |  |   |  |                   |  |   |  | 5 yrs  |
| DUE TO, OR AS A CONSEQUENCE OF <i>Lymphocyte Leukemia</i>  |  |  |   |  |                   |  |   |  | 2 yrs  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)  |  |  |   |  |                   |  |   |  |  |
| 19a. DATE OF OPERATION   |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                    |  |                   | 20a. AUTOPSY?  |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |  |
|  |  |  |   |  |                   | YES <input type="checkbox"/> NO <input type="checkbox"/>   |   | YES <input type="checkbox"/> NO <input type="checkbox"/>       |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR                        |  |                   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)   |   |  |  |
|  |  |  | P.M. 19   |  |                   |  |   |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  |                   | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |   |  |  |
|  |  |  |   |  |                   |  |   |  |  |
| 22. I certify that (I) (this hospital) attended the deceased from <i>1977</i> , 19____, to <i>12/15/79</i> , 19____, that (I) (we) lost saw the deceased alive on <i>11/29/79</i> , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (and not) view the body after death. |  |  |   |  |                   |  |   |  |  |
| 22b. SIGNATURE <i>S. Munoz M.D.</i>  |  |  | DEGREE  |  |                   | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |   | 22c. DATE SIGNED <i>12/15/79</i>                               |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  |  | 22e. ADDRESS  |  |                   |  |   |  |  |
| S. MUNOZ, M.D., P.A.   |  |  | 900 CATON AVE BALTIMORE MD 21229                                    |  |                   |  |   |  |  |
| 23a. BURIAL, CREMATION, REINTERMENT, OR OTHER DISPOSITION (SPECIFY) DATE   |  |  |   |  |                   |  |   |  |  |
| BURIAL IRS NO: 53020129 12/19/79   |  |  |   |  |                   |  |   |  |  |
| 23b. NAME OF CEMETERY OR CREMATORY   |  |  | 23c. LOCATION CITY OR TOWN COUNTY STATE                             |  |                   |  |   |  |  |
| LOUDON PARK CEMETERY   |  |  | BALTIMORE CITY, MD.   |  |                   |  |   |  |  |
| 24. FUNERAL DIRECTOR NAME ADDRESS  |  |  | 25. DATE REC'D. BY REGISTRAR  |  |                   | 25b. REGISTRAR'S SIGNATURE   |   |  |  |
| HUBBARD FUNERAL HOME 4107 WILKENS AVE. 21129   |  |  | DEC 17 1979   |  |                   | <i>Anthony McCreedy</i>  |   |  |  |





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  |   |  |   |  |   |  |
|--|--|---|--|---|--|---|--|---|--|
| 1. FOR STATE REGISTRAR <u>Thomas</u>   |  | REG. NO. <u>79 30678</u>  |  | 1. DECEASED NAME (TYPE OR PRINT) <u>Thomas M. Summerville</u>   |  | 2a. DATE OF DEATH MONTH <u>12</u> DAY <u>31</u> YEAR <u>'79</u>   |  | 2b. HOUR <u>8:55 PM</u>   |  |
| 3. SEX <u>MALE</u>   |  | 4. RACE <u>Black</u>  |  | 5. DATE OF BIRTH MONTH <u>7</u> DAY <u>24</u> YEAR <u>27</u>  |  | 6. AGE (IN YEARS LAST BIRTHDAY) <u>52</u> YRS   |  | IF UNDER 1 YEAR MONTHS <u></u> DAYS <u></u> IF UNDER 74 HRS HOURS <u></u> MIN <u></u> |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN) <u>Maryland</u>  |  | 7b. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH <u>City, Baltimore</u> MD.   |  |   |  |
| 10. CITY OR TOWN OF DEATH <u>City</u>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>Luthersu Hospital</u> |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>Maixtance</u>  |  | 12b. KIND OF BUSINESS OR INDUSTRY <u>sanitation</u>   |  |   |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) <u>1445 N. Fulton Ave.</u>  |  | 13b. COUNTY <u></u>   |  | 13c. CITY OR TOWN <u>City, Balto.</u>   |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |  | 13e. STREET ADDRESS <u>1445 N. Fulton Ave.</u>  |  |
| 14. FATHER'S NAME FIRST <u>Samuel</u> MIDDLE <u></u> LAST <u>Summerville</u>   |  | 15. MOTHER'S MAIDEN NAME FIRST <u>Rose</u> MIDDLE <u>Holmes</u> LAST <u></u>  |  |   |  |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <u>No</u>  |  | 16b. SOCIAL SECURITY NO. <u>217-22-6112</u>   |  | 17. INFORMANT ADDRESS <u>Mrs. Dorothy Summerville 1445 N. Fulton Ave.</u>   |  |   |  |   |  |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cardio resp. arrest</u><br><u>430-</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>coma 2° ? subarachnoid</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>Hemorrhage</u> |  |   |  |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>12/27/79</u><br><u>12/31/79</u>    |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)   |  |   |  |   |  |   |  |   |  |
| 19a. DATE OF OPERATION <u></u>   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <u></u>  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <u>19</u>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |   |  |   |  |
| 22a. I certify that (if this hospital) attended the deceased from <u>12/27</u> , 19 <u>79</u> , to <u></u> , 19 <u></u> , that (we) lost <u>saw the deceased alive on 12/31/79</u> , and that in (our) opinion death occurred on the date and hour and from the causes stated above, (we) (did) (not) view the body after death.                                 |  |   |  |   |  |   |  |   |  |
| 22b. SIGNATURE <u>R. Thiaga Rajan</u>  |  | DEGREE <u>M.D.</u>  |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>    |  | 22c. DATE SIGNED <u>12/31/79.</u>   |  |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>R. THIAGARAJAN M.D.</u>   |  | 22e. ADDRESS <u></u>  |  |   |  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>  |  | 23b. DATE <u>1-5-80</u>   |  | 23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Zion Cem.</u>   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE <u>Baltimore</u>  |  |   |  |
| 24. FUNERAL DIRECTOR NAME <u>Joseph L. Russ</u>  |  | ADDRESS <u>2222 W North Ave.</u>  |  | 25a. DATE REC'D. BY REGISTRAR <u>JAN 7 1980</u>   |  | 25b. REGISTRAR'S SIGNATURE <u>Dorothy McCreedy</u>  |  |   |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, this page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  |   |  |  |  |   |  |
|---|--|--|--|---|--|--|--|---|--|
| 1- FOR STATE REGISTRAR  |  | 7 9 3 0 6 7 9  |  | REG. NO.  |  |  |  |   |  |
| 1 DECEASED NAME (TYPE OR PRINT)<br>Baby Girl Swarey   |  |  | 2a DATE OF DEATH MONTH DAY YEAR<br>December 27, 1979       |   |  | 2b HOUR<br>3:05 AM   |  |   |  |
| 3 SEX<br>Female   |  | 4 RACE   |  | 5 DATE OF BIRTH MONTH DAY YEAR<br>December 25, 1979   |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br>YRS 0 2  |  | 7 UNDER 1 YEAR<br>MONTHS DAYS   |  |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland  |  | 7b CITIZEN OF WHAT COUNTRY?<br>USA   |  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD   |  |   |  |
| 10 CITY OR TOWN OF DEATH<br>BALTIMORE   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>ST. AGNES HOSPITAL |  |   |  | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)   |  | 12b KIND OF BUSINESS OR INDUSTRY  |  |
| 13a STATE<br>Maryland   |  | 13b COUNTY<br>St Mary's  |  | 13c CITY OR TOWN<br>Mechanicsville  |  | 13d INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 13e STREET ADDRESS  |  |
| 14 FATHER'S NAME FIRST MIDDLE LAST<br>MOSES S SWAREY  |  |  | 15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>NANCY K EDOOK |   |  |  |  |   |  |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>No  |  | 16b SOCIAL SECURITY NO<br>none   |  | 17 INFORMANT ADDRESS<br>Moses S.Swarey Mechanicsville, Md.  |  |  |  |   |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <del>Respiratory distress</del> Cardiorespiratory arrest<br>7621<br>DUE TO, OR AS A CONSEQUENCE OF (b) respiratory distress<br>DUE TO, OR AS A CONSEQUENCE OF (c) history of pleurisy<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |  |  |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)   |  |  |  |   |  |  |  |   |  |
| 19a DATE OF OPERATION   |  | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |  | 20a AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |  |  |   |  |
| 21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f LOCATION STREET CITY OR TOWN COUNTY STATE   |  |  |  |   |  |
| 22a I certify that (I) (this hospital) attended the deceased from 12-27, 1979, to 12-27, 1979, that (I) (we) last saw the deceased alive on 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.   |  |  |  |   |  |  |  |   |  |
| 22b SIGNATURE<br>[Signature]  |  |  |  | DEGREE<br>M.D.  |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c DATE SIGNED   |  |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT)<br>DR. Salcedo.  |  |  |  | 22e ADDRESS<br>900 CATON AVE. BALTIMORE, MD. 21229  |  |  |  |   |  |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial  |  | 23b DATE<br>Dec. 28, 1979  |  | 23c NAME OF CEMETERY OR CREMATORY<br>Hurtzler Cem.  |  | 23d LOCATION CITY OR TOWN COUNTY STATE<br>Mechanicsville St. Mary's Md.  |  |   |  |
| 24 FUNERAL DIRECTOR NAME<br>W. Clarke Mattingley  |  |  |  | ADDRESS<br>Leonardtwn, Md   |  | 25a DATE REC'D. BY REGISTRAR<br>JAN 4 1980   |  | 25b REGISTRAR'S SIGNATURE<br>[Signature]  |  |

BALTIMORE CITY

USA

ST. AGNES HOSPITAL

BALTIMORE

Harvard St Mary's Hospital

none cases S. Swamy Hospital

FOR CATION AND BALTIMORE, MD. 21202

Dec. 28, 1972

ending

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  | 7 9 3 0 6 8 0<br>REG. NO.   |  |  |   |
|---|--|--|--|---|--|--|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>LOGAN CHARLES SWITZER</b>  |  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>10 24 79</b>   |  |  |   |
| 3. SEX<br><b>MALE</b>   |  | 4. RACE<br><b>CAUC</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>10 24 79</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>IF UNDER 1 YEAR MONTHS DAYS<br>IF UNDER 24 HRS. HOURS MIN.<br><b>7</b>                  |   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MARYLAND</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.  |   |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>SINAI HOSPITAL</b> |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>NEWBORN</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY  |   |
| 13a. STATE<br><b>MARYLAND</b>   |  | 13b. COUNTY<br><b>AA</b>   |  | 13c. CITY OR TOWN<br><b>GLENN BURNIE</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                                       |   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>GERALD C SWITZER</b>   |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>SHARON LEE KELLY</b>  |  |  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>   |  | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT<br>ADDRESS<br><b>KATHLEEN STEWENS, M.D.</b>   |  |  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CARDIAC ARREST</b><br><b>7707</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) <b>PNEUMONIA</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) |  |  |  |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>6:45 HRS</b> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |  |  |   |  |  |   |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |   |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>OCT 24</b> , 19 <b>79</b> , to <b>OCT 24</b> , 19 <b>79</b> , that (I) (we) lost saw the deceased alive on <b>OCT 24</b> , 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |  |  |   |  |  |   |
| 22b. SIGNATURE<br><b>Kathleen Stevens, MD</b>   |  |  |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>        |  | 22c. DATE SIGNED<br><b>10/24/79</b>  |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>KATHLEEN STEWENS</b>  |  |  |  | 22e. ADDRESS<br><b>SINAI HOSPITAL 100</b>   |  |  |   |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>CREMATION</b>   |  | 23b. DATE<br><b>11/26/79</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>SINAI HOSPITAL</b>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore MD.</b>   |   |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS  |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JAN 14 1980</b>   |  |  |   |

BP

